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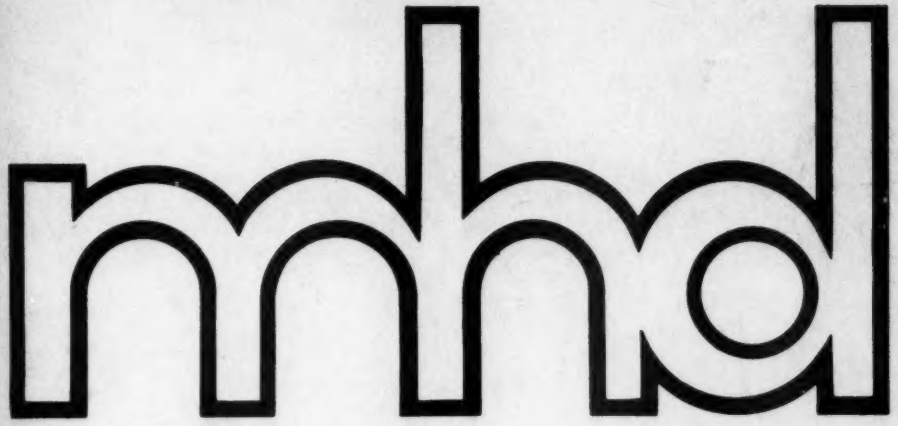

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The *Mental Health Digest* is a monthly publication designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view. It contains condensations of material selected from the current mental health literature. The condensations are published with the approval of the authors and publishers for use in the *Mental Health Digest* only. Readers interested in particular digests are urged to consult the journal or other source in which the material first appeared or to ask the authors for reprints.

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The Law and Mental Health

At the point where the law intersects with mental health research and service, there is an ongoing process of accommodation and assimilation. The conduct of research and the administration of services in the mental health field are bound by society's legal framework, so legislative changes and precedent-setting cases shape subsequent developments in mental health practice and scientific investigations. On the other hand, mental health disciplines have contributed to the development of law, and, as concepts of mental health and mental illness have changed, those changes have been reflected in the law.

This issue of the *Digest* features only a few of the issues where the complex interrelationships of the law and mental health are evident:

- The legal concept of mental illness has changed from one of irreversible madness that required only incarceration to one of a curable condition that merits systematic and humane treatment.
- The token economy, a popular behavioral technique, could be rendered ineffective by legislative reform.
- Passage of the Equal Rights Amendment will necessitate sweeping reforms in our nation's sexually segregated correctional system.
- Courts trying medical malpractice cases now will accept claims for mental anguish even in the absence of physical impact.
- Empirical experimental techniques adapted from social and behavioral science currently are being used to test the impact of legislation and of legal practices.
- Often the law has been used as an instrument to sustain discriminatory practices toward minority groups.

The discipline of jurisprudence and the disciplines of the behavioral and social sciences are concerned with human affairs. Their investigations and their interventions are sometimes theoretical and scholarly, sometimes intimate and practical. Those who design and implement mental health practices must maintain a constant dialog with those who design and implement the law in order for both parties to optimally serve the aims of justice and the treatment and prevention of mental illness.

We wish to acknowledge the valuable assistance of Rollee H. Lowenstein, J.D., Chief, Legislative Services Branch, NIMH, in the selection of the articles and in reviewing the part of this manuscript dealing with mental health and the law.

Jacquelyn H. Hall, Ph.D.
Guest Editor

Overview: Current Trends in Mental Health Laws

A. Louis McGarry and Honora A. Kaplan

A major new legal thesis in America is that adequate treatment for the institutionalized mentally ill and mentally retarded is a constitutional right. In particular, the class action suit has emerged as a mechanism with the potential for unprecedented and accelerated change in mental health systems.

Implicit and, in some cases, explicit in this activity is the requirement that the States reorder their priorities in order to provide adequate resources for the care and treatment of the mentally ill and retarded. Ironically, the charge comes at a time when a number of the States have been forced to cut their mental health budgets.

Historical Background

In earlier times the primary concern of legislation relating to mental illness was the protection and security of society. In Colonial America the violent insane were treated as common criminals and incarcerated in jails; the indigent or dependent insane often roamed the countryside, literally without a home.

During the late 18th century and early 19th century, when local communities began to deal with mental illness in a more organized fashion, jails and poorhouses were again used as solutions for the violent and indigent insane. There were, however, no statutes during this period that related to commitment of the mentally ill. Since only the violent or indigent were involved, commitment was easily accomplished.

The early 19th century brought significant reform to the treatment of the mentally ill. Treatment and cure (rather than incarceration and punishment) seemed possible and desirable. The philosophy of "moral treatment" advocated the resocialization of the mentally ill individual within an institutional setting where his environment could be completely and therapeutically structured. The asylums providing moral treatment had selective admission policies and achieved impressive success. This "cult of curability," coupled with the effective humanitarian crusades for better care and treatment for the insane led by Dorothea Dix, resulted in the establishment of a network of public facilities for the insane. However, procedures for commitment remained undefined by statute.

The assumption by the government of responsibility for the mentally ill represented a significant change in public policy. Public institutions, however, could not be selective in their admission policies. Within a short period of time public hospitals exceeded their bed capacities, while patient turnover was almost nonexistent. State facilities thus evolved into custodial, rather than therapeutic, entities, differing little from other custodial institutions, such as jails and poorhouses.

During this period of rapid growth of public asylums, a concern for the rights of the individual who had been committed to such a facility began to develop. This interest resulted more from public anxiety over the wrongful commitment of the sane than from a desire to protect the rights and liberty of the mentally ill. Consequently, during the 1870's a number of States enacted rigorous commitment laws, and the overly legalistic approach to mental illness and civil commitment con-

tributed to the stigma attached to mental disease.

There was no major impetus for changing commitment laws until the middle of the 20th century. After World War II, there was a growing conviction in the psychiatric community that the criminal law features of commitment statutes, including such concepts as notice and judicial hearings, were detrimental to the treatment of mental illness. Model legislation was drafted that dispensed with criminalistic terminology, jury trials, and judicial procedures to decide the issue of commitment. New statutory provisions permitting commitment for varying periods of time based wholly on psychiatric certifications (rather than on judicial determinations) reflected this approach.

More recently attention has focused on the rights, treatment, and living conditions of the mentally ill and retarded after they have been admitted to mental health facilities.

With the widespread growth of the open-door policy in mental health facilities and with the increase in voluntary admissions during the past 2 decades, we have entered still another new era in mental health law. Increasingly, the relationship between the mental patient and the mental health facility is taking on a contractual character with options on both sides of the contract. The courts are being used less frequently; the dignity and autonomy of the patient are enhanced; and mental hospitalization is further decriminalized.

Judicial Decisions

Law is interpreted, modified, changed, and expanded both through statute and through judicial decision. As a general rule, broad, prospective legal change is effected through legislation; decisional or case law is traditionally more limited and remedial, determining the rights and obligations of particular persons or parties.

The last 2 decades have been characterized by the establishment and expansion of civil, criminal, and consumer rights through judicial decision. This general model of heretofore powerless and neglected groups in society, utilizing the judicial system as both a forum for the expression of legitimate grievances and as an effective and responsive vehicle for social change, is now being adopted by and for the mentally disabled.

Class actions—Legal efforts on behalf of the mentally ill and retarded have been procedurally facilitated by the use of the "class action" mechanism in particular. In essence, class actions are representative law suits brought by a group of individuals who represent the interests of an indeterminate number of persons sharing the same legal claim against an alleged common wrongdoer or defendant.

Class suits were originally utilized to provide legal recourse to persons who had relatively small but legitimate claims and who lacked the financial resources to pursue such an action unless they were able to amalgamate claims with similarly injured persons. However, the modern approach to class actions is encouraging litigation where a remedy is theoretically, but not practically, available—as in consumer class actions where each class member has been injured in a small way, but where the aggregate injury is great. The current emphasis is thus placed on the potential impact of the remedy, rather than on the financial ability to bring suit.

To bring a class suit requires an "ascertainable class" or a clearly defined group of persons with common interests. The facts and law that would permit recovery to one member

of the class bringing the suit must permit recovery to all members of the class. In terms of recovery, the class action is more effective in obtaining injunctive relief (i.e., a court order that the defendant either cease or take particular actions) than in awarding compensation or monetary damages. In the area of mental health and retardation the legal relief sought by mental patients has most often been injunctive in nature (e.g., that the physical facilities and treatment services of institutions be improved); therefore the class action can be a particularly appropriate and effective vehicle for such purposes.

While a comprehensive compilation of judicial decisions relating to the mentally disabled is beyond the scope of this paper, we will attempt to categorize and evaluate the impact of some of these decisions. Case law is binding only within the jurisdiction of the court rendering the decision; consequently, a decision of one State need not be followed in another. But since the common law system is based on precedent, the influence and impact of a particular decision, especially in a substantive area where there is little case law, can be impressive.

Right-to-treatment decisions—Of major significance is the recent line of cases recognizing the right to treatment of institutionalized mentally ill and mentally retarded persons. Beginning with the landmark decision in *Rouse* v. *Cameron* in 1966, the District of Columbia Circuit Court of Appeals held that mental patients committed by criminal courts had the right to adequate treatment. The mental condition of such persons had resulted in their being found not guilty by reason of insanity; thus punishment and incarceration were precluded. But confinement in a high-security mental hospital *without adequate treatment* was held tantamount to incarceration, transforming the hospital into a penitentiary. Two years later, again in the context of criminal commitments to mental hospitals, Massachusetts extended the right to treatment to persons found incompetent to stand trial.

In 1971, in response to a class action, an Alabama Federal District Court further extended the right to adequate treatment to all mentally ill and mentally retarded persons who were in institutions involuntarily, whether their commitments were under civil or criminal procedures. The court issued an order in 1972 that detailed the criteria for adequate treatment in three areas: a humane psychological and physical environment, a qualified staff with a sufficient number of members to administer adequate treatment, and individualized treatment plans. However, the focus in the 1972 *Wyatt* v. *Stickney* order is exclusively on the allocation and expenditure of State funds for mental health institutions. Given limited resources for mental health services, the widespread application of the explicit and comprehensive *Wyatt* standards and requirements could be antithetical to the general movement toward community alternatives to institutional care. In October 1972, Judge Johnson, who wrote the *Wyatt* opinion, further applied its holding to require adequate medical treatment, including psychiatric services for prison inmates.

These cases involved patients involuntarily committed under civil or criminal law. The increasing utilization of voluntary admissions to mental hospitals substantially mitigates the "incarceration" component of involuntary hospitalization. However, while the issue of adequacy of treatment for voluntarily admitted patients

has not yet been addressed by the courts, there is no medical, legal, or ethical justification for compromising the quality of care and treatment at a mental health facility because of the legal status of the recipient. Minimum standards for adequate treatment should be no different, and certainly no lower, for voluntary patients than for involuntary patients. The constitutional guarantee of equal protection under the laws, particularly when one is dealing with State facilities, should mandate such a result.

Mental retardation law suits—Class actions on behalf of mentally retarded residents in State facilities have been brought in New York, in Massachusetts, in Illinois, and unsuccessfully (pending appeal) in Georgia. As in the *Wyatt* model, the plaintiffs seek the establishment and implementation of standards for adequate treatment and the improvement of the physical plant and treatment services. In the area of patient labor, class suits are under way in Tennessee and in Florida alleging the unconstitutional servitude of mentally retarded residents required to perform services in State facilities.

In an important decision in Pennsylvania in 1971, a Federal court ordered that all mentally retarded children there be accorded access to a free public education program appropriate to their learning capacities. The potential impact of this decision on the custodial mental retardation facility could be enormous. In the District of Columbia plaintiffs in a class action had been suspended from school because of mental, behavioral, physical, or emotional handicaps or deficiencies. The court initially ordered the reenrollment of the named plaintiffs and the identification and readmission of other members of the class. In March 1972, judgment was made in favor of the plaintiffs, although the detailed order has not yet been handed down. In California a suit is currently being brought on the grounds of denial of education to a mentally retarded child in response to the State's attempt to terminate her placement in a State facility because of her "non-educability." To date, the court has enjoined the State from interfering with the child's education until a final judicial determination is made.

In accurate and arbitrary classification and placement of mentally retarded children and the denial of their right to education is the basis for pending law suits in California, Louisiana, and New York. Other pending right-to-education suits are being brought in Michigan and in North Carolina; others deal with autistic children (California), special education in general (Delaware), and emotionally disturbed children (Massachusetts).

There have been several decisions delineating other rights of the mentally disabled. In *Commonwealth* v. *Wiseman* the Massachusetts Supreme Judicial Court established the right to privacy of institutionalized mental patients and prohibited their commercial exploitation. In New York a Federal court held that an involuntarily committed mental patient whom the court had not found incompetent was constitutionally guaranteed the right to refuse certain kinds of treatment because of religious beliefs. Still another court held that it would not permit the sterilization of a mental retardate who had given birth to two illegitimate children because the patient was unable to give consent.

The examples cited here represent some of the current judicial thinking in the area of mental health and retardation, and it is likely that these decisions will have an impact beyond their jurisdictions. Case law, however,

is essentially a response to past injustices and wrongs; appropriate redress is traditionally made to particular persons in particular situations. Thus judicial solutions, while occasionally broadly and innovatively applicable, are ordinarily limited in scope and tied to the past.

Statutory Change

Comprehensive and prospective legal change in protecting the rights of and providing services to the mentally disabled can be found primarily in legislative measures. In the past few years a number of States have enacted new legislation or have recodified and amended their existing statutes relating to mental health and mental retardation. An examination of some of these new laws has suggested several trends, or at least common problem areas for which legislative solutions have been undertaken.

The trends and changes in the new mental health statutes are generally in response to two broad problem areas: the debilitative and dysfunctional effects of long-term custodial institutionalization, and the neglect and abrogation of the rights and personal dignity of individuals committed to hospitals for indeterminate periods of time. The thrust of new mental health legislation has thus been toward shorter hospital stays, community alternatives to institutionalization, legal protection of the patient's rights, and substantial guarantees of the quality of treatment while under the care of the facility.

Variety of admission statuses—Less than 25 years ago the World Health Organization reported that only slightly more than 10 percent of the admissions to State mental hospitals in the United States were voluntary. In contrast, more recent statutes provide a number of alternative routes to hospitalization and a variety of admission statuses. In addition to involuntary admissions there are the informal voluntary admissions based on the general hospital model. Another more common voluntary admission status is a limited or conditional one in which release requires written notice and a lapse of generally 3 to 10 days. There are also pretreatment statuses such as emergency, diagnostic, and evaluative admissions that are usually of short duration and often precede admission for planned care and treatment.

The diversity in admission statuses, as well as the documented increase in the numbers of voluntary admissions to mental hospitals, indicates substantial legislative effort to put an end to hospital stays of unlimited duration in which the patient could not initiate his discharge or release. It also represents an increasing sophistication and an accommodation of the hospitalization episode to the particular needs of the particular patient. Finally, it represents enhanced emphasis on the rights of mentally disabled persons to freedom of movement and to self-determination.

Classification of mentally ill and mentally retarded persons—One of the disparate elements of the new mental health statutes is their inconsistent manner of classifying or categorizing mentally ill and mentally retarded persons. This is partly the product of the differential variety of admission statuses available under the new laws. There are other distinctions as well. For example, eligibility for consenting admission to facilities often depends on age, ranging from 14 years in Georgia and Florida to 18 years in most States. This disparity reflects the ambiguity in classifying adolescents as either children or adults.

In the past mental illness, epilepsy,

mental retardation, and senility have often been jumbled together into a single statutory provision. Of special significance in recent legislative reform has been the degree of awareness and sophistication in particularizing these disabilities. For example, mental retardation has been clearly differentiated from mental illness. New laws require the development of services that are adapted and appropriate to the needs of the mentally retarded, and levels or degrees of retardation have now been recognized in statute and regulation.

Few of the recent mental health statutes have reformed procedures relating to the category of the psychiatric offender, i.e., the mentally ill person who is within the criminal law system. Generally, provisions relating to this area will be found in the criminal statutes. Procedures governing the mentally ill criminal offender have tended to be neglected even in those States which have undergone substantial revision of their mental health statutes. There is a risk here that when civil statutes governing the mentally ill become procedurally complex, or when standards for civil commitment become more restrictive, recourse to simpler criminal procedures may increase. In California, with its new, restrictive civil procedures, an increase in the use of criminal procedures has been reported. It is a relatively simple matter to allege "disorderly conduct" or "disturbing the peace" against a mentally ill person and bring about a commitment in a mental hospital based on the question of his competency to stand trial.

However, attention is being focused on this area in case law, and it is likely that statutory reform will eventuate in the area of the mentally ill offender.

Limitations on involuntary commitment—Closely linked to the greater variety of admission statuses and to the increasing use of voluntary admission have been significant limitations on the wholesale use of involuntary commitment. The statutory standard for involuntary commitment has become somewhat more stringent in a number of States, contributing to a decreasing number of involuntary commitments.

New statutory restrictions on involuntary commitment have had an effect on the institutionalization of the mentally retarded. In Massachusetts, for example, there can be no involuntary commitment of mentally retarded persons who are not also mentally ill. In some of the newer statutes providing for the involuntary commitment of the mentally retarded, the standard for commitment is distinct from that for commitment of the mentally ill.

Procedurally, involuntary commitment may be accomplished through the courts or through the medical certification of mental disability by a psychiatrist. In some of the new statutes a variety of commitment mechanisms have evolved, each appropriate to the particular involuntary status involved. For example, medical certification is often utilized for brief periods of involuntary hospitalization, such as emergency care. Judicial commitment usually relates to longer commitments and is accompanied by the full panoply of legal protections such as notice, hearing, representation by counsel, and so forth. Falling somewhere between these procedures is a quasi-judicial or administrative commitment carried out by hearing officers and subject to judicial review.

These statutory measures serve to restrict the availability and unnecessary utilization of involuntary commitment for long periods of time. In so

doing they force closer scrutiny of the clinical status and particular needs of the mentally disabled individual and militate against the neglect of institutionalized patients.

Orientation of facilities toward the community—A number of the new mental health laws reflect the general shift in mental hospital treatment toward "open-door" policies and the effort to abolish locked and neglected back wards. New statutory provisions set forth explicit internal procedures for patient management and for administration of the institutions. For example, some provisions were designed to result in shorter patient stays. Others mandate periodic clinical review with a view toward discharge and continued treatment in the community. The Massachusetts statute specifically requires the consideration of alternatives to hospitalization in its periodic review provision, while the Illinois law sets forth a similar requirement in its commitment hearings. It is likely that these provisions will contribute to an increasing patient turnover and a decreasing hospital census.

The orientation of mental health programs toward the community, as well as the increasing use of voluntary hospitalization, represents acceptance into and by society of its mentally ill citizens and narrows the differences in legal and social status between the mentally healthy and the mentally ill.

Trends related to patients' rights—Explicit statutory recognition in recent legislation of the civil and personal rights of the mentally ill and mentally retarded not only constitutes significant and needed reform, but also indicates the kinds of discrimination and illegal restrictions that had been placed on the mentally disabled in the past. Enumerated in recent legislation are such rights as that to communicate with persons outside the facility (via correspondence, telephone, and visits); to keep clothing and personal effects; to religious freedom; to vote; to be employed if possible; to manage or dispose of property; to execute instruments such as wills; to enter contractual relationships; to make purchases; to education; to habeas corpus; to independent psychiatric examination; to civil service status; to retain licenses, privileges, or permits established by law; to sue and be sued; to marry; and not to be subject to unnecessary mechanical restraints. Mental illness does not necessarily impute incompetency in exercising one or more of these rights, and incompetency requires specific judicial determination.

The right to legal representation—The constitutional guarantee of the right to counsel or legal representation has been incorporated into a number of new mental health statutes to protect the rights of patients in commitment hearings, including the appointment of counsel for indigent persons. The participation of an attorney representing the interests of the patient precludes the appearance of railroading commitment and establishes a true "adversary" setting, ensuring close adherence to statutory commitment standards.

Legal representation of patients' rights and interests indicates a fundamental change in attitudes toward the mentally disabled; no longer is the mental patient passively subject to the legal, economic, and personal consequences of his illness, but may, with legal assistance if necessary, affirmatively and actively continue to control his own life.

Privacy and confidentiality—Protecting the privacy of mental patients, as well as the confidentiality of their communications and medical records,

has become a significant legal concern. The "right of privacy" implies the right of the individual to keep some information about himself or access to his personality (as by a photograph or personality test) completely secret from others. "Confidentiality," on the other hand, presupposes disclosure of certain information to another person; however, the communication of such information is limited to specifically authorized parties. "Privileged testimonial communication" is an evidentiary concept, permitting the patient or client to prevent his physician, psychologist, etc., from disclosing confidential communications in court or in other legal proceedings.

All but three States recognize the right of privacy in some form, while approximately two-thirds of the States have enacted physician-patient testimonial privilege statutes. In addition, most of the new mental health statutes specifically protect the confidentiality of patient records, and the Massachusetts statute goes on to protect patients "from commercial exploitation of any kind."

Informed consent—Another issue relating to patient rights is the ability or capacity of the mentally disabled individual to give informed consent to his "voluntary" admission, to particular kinds of treatment or therapy, to surgical procedures, or to scientific research. The case law regarding a mental patient's capacity to consent is ambiguous, and decisions support almost any position.

Statutory right to treatment—Corresponding to the growing body of case law relating to treatment, recent legislation has begun to articulate substantive guarantees of adequate and humane treatment. Such guarantees would appear to be enforceable in court, if necessary. However, criteria for judicial assessment of the adequacy of treatment received remains a problematic area.

In one sense we have now come full circle in mental health law since the days of the "moral treatment" of the mentally ill when treatment was adequate, but only for the few. Now we are required to provide adequate treatment, but for the many. Fortunately, with the significant advances in the treatment of the mentally ill in the past 20 years, we should be able to make accelerated progress toward such a desideratum. This will require increased allotment of public resources for the mentally ill and the mentally retarded. However, much can be accomplished by the reallocation and more productive utilization of the resources we now have.

The role of the law that has emerged in recent years may be regarded as catalytic toward improving care and treatment for the mentally disabled. If some of the new statutes and case law appear to be excessively rigid or burdensome in their implementation, or if these reforms appear at times to be advanced by overly aggressive and overzealous lawyers, it is well to remember that there is no conflict regarding the ultimate ends to which all this energy is directed. Change is painful, but we know that it is both necessary and inevitable if we are to have progress.

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Reflections on Experimental Techniques in the Law

Hans Zeisel

During the last decades, the natural and social sciences have developed techniques of experimentation that would allow firmer determinations of what a rule of law does or does not accomplish.

The basic tool is the controlled experiment. Its essence is simple: The devices of random selection, experimental treatment groups, and control groups are employed together so that if an effect is found in the experimental group that is absent from the control group, it can be attributed to the experimental treatment. Then, whatever the outcome of the experiment, it is possible to calculate the degree of certainty that can be attached to it.

Several controlled legal experiments have been or are being conducted, but sometimes the controlled experiment, employed for legal investigations, encounters obstacles on the part of the law. Since by definition it gives something to one group and withholds it from another, it would seem to violate the basic guarantee of equality before the law.

Several circumstances, nevertheless, argue in favor of the experiment, even in legally sensitive areas. First, it is by no means certain that the experimental treatment makes any difference; the uncertainty may in fact be the reason for the experiment. Second, discrimination in an experiment is by definition only temporary; after it is concluded and the best solution is found, the solution will be applied to all. Finally, there are areas at the fringe of the law where random assignment is more tolerable because the right involved is not sufficiently important to merit special protection.

Certain modifications have been developed that make controlled experimentation tolerable even in sensitive areas. They operate in three dimensions: abandonment of direct control of the experimental treatment in favor of the indirect experiment, simulation of part of the experimental design, and the use of natural experimental conditions.

The Indirect Experiment

The essence of the indirect experiment is that it removes direct control over the experimental variable from the investigator while maintaining the controlled character of the experiment, albeit at a price.

Split trial procedure—The first of the indirect experiments concerned a procedural device designed to reduce the trial load of the courts. Normally, a claimant in our civil courts presents his case as to both liability and size of damages; he is followed by the defendant who presents evidence in rebuttal of both claims. Next the jury decides whether the defendant is liable for damages, and if so, how large these damages should be. The question of damages thus becomes relevant only if liability is found. It was proposed to try the liability issue in its entirety first and ask the jury to decide whether the defendant owed anything at all. Only if liability was affirmed would the trial continue, and, since liability is found in only slightly more than half of all cases, this was expected to dispense with about half of all damages litigation. The U.S. District Court for Northern Illinois permitted by rule the conduct of split trials, and asked the University of Chicago Law School to assess its effect on the workload of the court.

As the cases came to the court they were randomly assigned to the individual judges. The various judges made differential use of the split rule, in that some used it for almost all their cases, some for hardly any, and some for varying proportions in between. If it were true that the application of the split trial rule saved time, the judges who applied the rule more often should require on the average less trial time than those who applied it less often.

This turned out to be the case. The regression line based on experimental data indicated that if a judge were to conduct all trials under the split trial rule, his average trial time would be cut by about 20 percent. This would be, then, the amount of time that could be saved through general application of the split trial rule.

This particular experimental design, however, contained a hidden flaw. The judges who tried their cases in general more expeditiously might also have made more frequent use of the split trial rule; such self-selection could have biased the results of the experiment. Supplemental evidence was therefore adduced. It was clear that any savings had to come from the elimination of the damage trial, so the frequency of damage trials was determined both for the regular and for the split trials.

The dispositions of the two groups of cases differed drastically: 76 percent of all regular cases went through a complete trial as against only 15 percent of the split trials. In 58 percent of the split cases, trial of the damage issue was avoided because of the intermediate liability verdict. In 43 percent of the cases the trial simply ended when liability was denied and in another 15 percent there was no trial of the damages because the case was settled after the jury had found liability. The convergence of the two sets of data left no room for doubting the efficacy of the split trial rule.

Pretrial—The courts of New Jersey decided to appraise the value of pretrial. In most of our courts, civil suits are scheduled for pretrial before the regular trial. There, counsel for both sides meet with the judge to present briefly the issues under dispute and air the possibilities of a settlement. Tradition has it that the pretrial facilitates settlement and hence is a most desirable means of reducing the trial load and thereby the congestion of our metropolitan courts.

But analysis of the available evidence raised doubts as to whether pretrial in fact save court time since, to begin with, it uses up court time. Although the New Jersey courts had a rule that made pretrial obligatory, a compromise was agreed upon that allowed random assignment of one-half of the cases to obligatory pretrial and the other half to optional pretrial, where pretrial would be held only if at least one of the litigants requested it.

The experiment was conducted and 2,954 cases assigned randomly to the two groups. Only about one-half of all litigants in the optional group asked for pretrial, compared with the obligatory group where all cases were pretried.

The conclusion emerged simple and clean: Contrary to the widely held belief, obligatory pretrial failed to increase the settlement ratio; there were just as many settlements without it. From the point of view of reducing the number of trials, obligatory pretrial was found to be a waste of time, and the State of New Jersey forthwith changed its rule and made pretrial optional.

Setting bail—A third experiment revolutionized a solid tradition: the

practice of setting bail for arraigned defendants. Bail is set, as a matter of constitutional right, for virtually all defendants. If they can post it, they are set free; if not, they must remain in jail. Whether or not they can post it as a rule depends—since criminal defendants seldom have substantial sums of money—on the bondsman who, against a premium of some 10 percent, will or will not take the risk of providing the demanded bail.

The system has been criticized because it favors the well-to-do and the criminal-accused who work for the well-to-do, because it surrenders the actual power of decision to the bondsman, and because it keeps an inordinate proportion of defendants in jail, many of whom are subsequently acquitted. Nevertheless, the system stood fast until a foundation conducted a controlled experiment with the cooperation of the New York judiciary and the assistance of New York University Law School. All defendants arraigned in the felony court of Manhattan were interviewed to assess the risk of their failing to appear at their trial if the court freed them without requiring bail. On the basis of these interviews, the defendants were classified into two groups: those for whom release without bail could be recommended, and those for whom such a recommendation could not be made. The recommendable group was then divided at random in half. For one of the halves, the recommendation to release the defendant without bail was transmitted to the arraignment judge; with respect to the other half, the judge was told nothing. In all cases the judge made the ultimate decision as to bail. In the group without the recommendation, only 14 percent of all defendants were freed without bail, as against 60 percent in the recommended one-half. When trial time came, in both groups not more than 1 percent of all defendants deliberately failed to appear. The experiment demonstrated that the number of defendants released without bail could be approximately quadrupled without increasing the likelihood of defendant's not appearing at the trial.

The aftermath of this experiment was dramatic. The City of New York adopted the interviewing procedure as a permanent feature of the criminal justice system; today most major cities and many rural areas have adopted the interviewing procedure and with it the practice of release without bail. Everyone—except the bondsmen—stood to profit from the liberalization: the municipalities by saving money on jails; the defendants by being spared unnecessary hardship; not least, the ends of justice were advanced at a point where the traditional approach was ripe for reform.

In all three of these experiments the direct control over the experimental variable had been left to the judges or the litigants. But because of the prior random assignment of the cases to experimental and control groups, all three studies retained their character as controlled experiments. Two disadvantages result from such indirect control: a lack of directness in the measurement; and the lack of direct control could have vitiated the experiment. This shift in the goal, coupled with the risk of failure, are the price to be paid for the privilege of conducting an experiment in an area where the law cannot surrender certain decisions.

Simulation

The experimental sequences we now turn to involve simulation—another way in which the experimenter can meet the concerns of the law halfway. They were not undertaken by the law

itself, although assisted at crucial points by the judiciary or the litigants.

Verdicts by jury or judge—The question of the difference between jury and judge verdicts would seem to demand a controlled experiment, where every case is tried twice, once with and once without a jury—an obviously impossible solution. Yet this is almost precisely the experiment that was performed, if one permits the "two trials" to take place simultaneously, since every jury trial takes place also before a judge, the one who presides over it. A nationwide sample of trial judges were asked to reveal, for a sample of their trials, how the jury had decided the case and how he, the judge, would have decided it without a jury.

The results of this study, in criminal cases, indicate that judge and jury agree in 75 percent of all cases. Of the 24 percent disagreement cases, the jury is on the defendant's side in 22 percent, and on the prosecutor's side in 3 percent.

Insanity defense—In the Anglo-American system the defense of insanity has been embodied for more than a century in the so-called *M'Naghten* rule, under which the defendant is acquitted either if he did not know what he was doing or if he did not know that what he was doing was wrong. The rule has come under increasing criticism, primarily from psychiatrists, and in 1954 the U.S. Court of Appeals for the District of Columbia established the *Durham* rule, in which the defense of insanity was established if the criminal act was shown to be the "product of a mental disease or a mental defect."

For some time, the two rules competed for the favor of the nation's judiciary. The question as to what difference the law makes means what difference it makes to the jury whether the judge instructs it according to the rule in *M'Naghten* or according to *Durham*. Obviously the main question is how the two rules affect the defendant's chances of acquittal.

To test the issue, two trial records were composed—a case of housebreaking and an incest case. In both trials the accused's only defense was insanity. The trial evidence was acted out and, with the other elements of the trial, put on recording tape. Three variants of each case were produced. The tapes were identical except for that part of the judge's instruction that dealt with the defense of insanity and for the concomitant psychiatric testimony. In one version the instruction and psychiatric testimony were according to *M'Naghten*; in the second according to *Durham*; and in the third the instruction left it to the jurors' own judgment as to whether the evidence in the cases supported a defense of insanity, thus forcing the jury to establish its own law of insanity.

Each of the three versions was then taken into two major metropolitan courts and presented to some 100 juries in turn. The jurors would listen to the taped trial and afterwards deliberate and find a verdict.

In both trials, the *Durham* rule elicited a higher percentage of acquittals by reason of insanity than the *M'Naghten* rule. The percentages under *Durham* were very close to those obtained under the "no rule" instruction, suggesting—as it has been argued—that *Durham* comes close to being no rule.

Regional differences in awards for damages—There is a notion among lawyers that juries in some parts of the country are likely to award larger damages for a given injury claim than juries elsewhere. But there was no precise knowledge concerning either

the geographic pattern or the degree of variation.

A controlled experiment was designed by submitting simulated cases to the representatives of major insurance companies in various parts of the country. Five personal injury claims were composed by modifying and simplifying five actual personal injury reports. The cases were submitted to the claim adjusters with this question: "How much, judging from your experience, would you expect a jury in your court to award for this case?" The question was asked for a number of courts, which constituted a probability sample of regions and community sizes of the United States. The requests were submitted to three adjusters in each community, one from each of the three insurance companies that cooperated in the experiment.

It was found that awards for identical claims vary between roughly 80 percent of the national average in the rural South and Midwest to roughly 120 percent of that average in the large cities on the east and west coasts. The results can be translated into a formula: Add 10 percent to the average if the trial takes place on the east or west coast and another 10 percent if it is conducted in a large city; subtract 10 percent if it is conducted in the South or Midwest and another 10 percent if it takes place in a rural area. The variations were found to correlate highly with the average per capita income of the community.

As these examples illustrate, simulation opens another line of compromise where the experimenter can pacify the law's basic concerns. However, simulation is a more serious deviation from the ideal experiment than the "indirect experiment" is, because its impact cannot be readily measured but must instead be assessed intuitively and through circumstantial evidence. At a certain point, therefore, one might prefer to have less simulation even if it means giving up some of the rigor of the experimental design.

The Natural Experiment

The third escape route from legal constraints is to make use of what may be termed the "natural experiment." Here, random assignment has been part of the judicial process itself. A good example is provided by studies comparing judging or sentencing practices of different judges. Whenever a court assigns its cases randomly among its judges, the analyst may attribute with confidence differences in sentences to differences between judges, since the groups of cases that come before one or the other judge are as comparable as an experimenter could make them.

Randomization will not always be explicit. In some situations, natural events may be relied upon to provide random exposure. An example is the curve describing the relationship of driving accidents of women to their menstrual cycle: Auto accidents involving women drivers sharply increase on the days before and during the menses.

Because the natural experiment is far less costly than the artificially controlled experiment, the analyst is often tempted to bestow on natural events, without further proof, the character of a controlled experiment. For instance, when it became important to learn how criminal jury verdicts would be affected if the law were to allow majority verdicts instead of insisting on unanimity, it was natural to compare jury verdicts from Oregon (the only State that allowed majority verdicts) with verdicts from other States. The frequency of hung juries in Oregon turned out to be 3 percent as against 5 percent in other States. Ac-

ceptance of the comparison implied that the cases and the jurors in Oregon and in other States are as comparable as if they had been randomly assigned. But if the cases in Oregon are different from the cases in other States, or if Oregon jurors are more likely to agree with one another, we would attribute falsely to the difference in voting rules what in fact was the result of different types of cases or different types of jurors in the Oregon courts.

The importance of a randomized control group is well illustrated by a recent analysis. A major city has a methadone treatment program for which drug addicts may volunteer. To evaluate the effects of the program on the crime rate, the following data were produced: During the 12 months prior to admission to the program, the arrest rate per 100 volunteers had been 70; during the 12 months after admission, it had declined to 40. It was tempting to conclude that the methadone treatment was responsible for the decline in the arrest rates. But since there was no control group of volunteers who by random assignment were excluded from admission, there was no way of separating the arrest reduction due to the addict's motive to improve (expressed in his volunteering for treatment) from the effects of the treatment itself.

Retrospective Analysis

Situations created by explicit random assignment and situations in which random assignment, however likely in fact, is unproven are radically different. In the one situation, the analyst may assign emerging differences without hesitation to the different experimental treatments. In the other situation, he must assume that the cases in the compared groups may not have been interchangeable prior to the experimental exposure and that differences in the result may be due not to the difference in treatment but to differences that existed before the experimental treatment began. For example, sentences given to defendants convicted in jury trials are on the average higher than those given in bench trials in the same court system. But it would be incorrect to conclude from this comparison alone that judges reward defendants who waive their right to jury trial with a lower sentence. The cases that are tried before a jury are on the average more serious to begin with; hence, cases tried by a judge cannot be compared to cases tried by a jury as if they had been assigned randomly to these two modes of trial.

The technique of retrospective analysis is an attempt to arrange comparisons in a way that comes as close as possible to the comparison that would have been obtained through randomization, which would have made the two groups prior to the experimental treatment interchangeable. The analysis tries to approach this goal by breaking the overall group down into smaller segments which approach comparability. For example, instead of comparing sentences in all jury trials with those in all bench trials, one would compare such sentences separately for each particular crime category and for defendants of specified sex, age, and prior criminal record. The drawback of this procedure of fractioned analysis is that however far it is carried, there is no way of knowing for sure that all hidden factors that might render a causal inference spurious have been eliminated.

Retrospective analysis encounters still another difficulty that the controlled experiment eliminates. Technically known as the identification problem, it is the difficulty of deter-

mining (in retrospect) the temporal sequence of two factors. Suppose, for instance, that one were to find that in States in which the proportion of crimes in which the criminal is apprehended is high, the crime rate tends to be low. One might be tempted to conclude that it is the higher probability of apprehension that is responsible for the lower crime rate. But it could be the other way around: The fewer crimes, the more attention the police can pay to each, hence the greater the chances of apprehension. Or, the observed relationship between the two factors may reflect a mixture of both these effects. A controlled experiment that, at a certain point in time, increased the police forces in some areas but not others would resolve the problem.

Retrospective study uses essentially the same modes of analysis as the controlled experiment.

Whatever technique is used, however, retrospective analysis must reckon with the identification problem and the required interchangeability prior to the experimental exposure. Because it bypasses both these difficuties, the controlled experiment, where feasible, is the preferred research device.

The Problem of Extrapolation and Some Cautionary Conclusions

The controlled experiment is an operation with specific limits in time, space, and operating conditions. Hence, there is always the question as to how far its results can be extrapolated, that is, applied to other places, other times, and other conditions. The limitations of the controlled experiment are the price to be paid for the power of its analytical resolution. The endeavor must always be to choose a clearly defined experimental variable, and then test it under as many environmental conditions as possible.

Reading this report on a variety of legal experiments may create in some readers' minds the expectation that the law is rapidly approaching a stage where a great many of its premises will be tested through controlled experimentation. The law is very far from such a stance, and it would be a mistake to expect such a development.

There are many legal and practical constraints that set limits to experimentation. Both the costs of experimentation and the time it requires will often prove insurmountable obstacles. There is also the danger that an experiment may run into unforeseen barriers and thereby end inconclusively or fail altogether. There is also the occasional danger that an effect attributed to the experimental treatment was in fact caused by the subjects' awareness of being part of an experiment. Even if the experiment succeeds, it provides as a rule only part of the answer, and there is always the question of just how valuable that part is.

Despite these obstacles, a number of controlled experiments are now under way, two of them designed to explore the effects of potentially far-reaching reforms. The first was designed to discover whether a negative income tax would reduce the recipient's incentive to work. The other experiment explores the potential effects of a new idea for the rehabilitation of ex-drug addicts and ex-convicts. Since these men and women have a high propensity to fail in normal job situations, special working situations were arranged in which these people work among themselves, under appropriate counseling supervision. They are being paid a normal wage, although they are not quite earning it, the difference being made up from public funds. The expectation is that this supported work might be the

most productive way—in both economic and human terms—of spending welfare money.

A third experiment is designed to test the effects of peremptory challenges of jurors on the verdicts of juries. Trials are now being conducted before three juries, two of them mock juries seated in the spectator section; one consists of the jurors who have been excused by both sides, the other consists of a jury for which no challenges have been allowed.

There is one place in the law where the controlled experiment should play an increasingly important role. Occasionally, when a legal innovation is instituted, there is some lingering doubt as to whether it will work. Often such a tentative innovation is even labeled "experimental" in the sense of a tryout. For instance, before Great Britain abolished capital punishment permanently, it suspended it for a trial period of several years to see what would happen. But "to see what would happen" is very different from building an experimental design into the innovation in order to enable a precise evaluation of the enacted rule.

Whenever the expected consequences of a rule are at issue, the lawmaker should at least consider the possibilities of a controlled experiment. Even if he should decide not to undertake the experiment, the mere process of thinking through such a possible experimental design will have been useful. The growing insistence on "evaluation" of innovative projects eventually will lead to building into such projects the elements of controlled experimentation.

Controlled experimentation, of course, is but one of the approaches, and in a sense the sharpest one, of exploring legal issues empirically. In the end, the law's attitude toward experimentation is necessarily but part of its more general attitude toward systematically collected, scientifically analyzed data. And in this perspective the signs are encouraging.

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Reprints of original article from Hans Zeisel, J.D., Professor of Law and Sociology, University of Chicago, 5801 S. Ellis, Chicago, Ill. 60637

The Sexual Segregation of American Prisons

Ralph R. Arditi, Frederick Goldberg, Jr., M. Martha Hartle, John H. Peters, and William R. Phelps

Despite recurrent interest in both penal reform and women's rights, little attention has been given to the differential treatment of male and female inmates in American prisons. This article examines those differences and assesses their constitutionality in light of the Fourteenth and proposed Equal Rights Amendments.

Data were obtained in three ways: First, information on correctional institutions was solicited from the corrections department of every State and the U.S. Bureau of Prisons. Second, personal visits were made to the women's prisons of nine States and to the Federal correctional institutions at Danbury, Conn., Fort Worth, Tex., Terminal Island, Calif., and Alderson, W. Va. Finally 15 sample States were chosen on the basis of size and geographic location. Selected institutions in these States were then surveyed through telephone interviews. The survey encompassed 47 male and 15 female institutions, which account for approximately 30 percent of the men and 50 percent of the women incarcerated in prisons throughout the United States.

Usually, each State and the Federal Government operate two separate prison systems—one for men, the other for women. In part, the differences between those systems are related to their vastly different scales. Of the nearly 200,000 inmates in State and Federal prisons, less than 6,000 are women. Since neither the States nor the Federal Government have established optimal population levels for their institutions, prisons which house men tend to have substantially greater populations than those for women. Such size disparities lead to differences in treatment and to the distinct atmospheres that characterize large and small institutions.

The decision to segregate has been based in part on stereotypical assumptions about the different security and rehabilitative problems posed by male and female inmates. Institutions which house members of only one sex can be structured and operated in accordance with these perceived differences, and thus eliminate pressure for standardized treatment. Scale differences in turn often reinforce this tendency toward sexually stereotyped prison programs—for example, smaller institutions are more conducive to individualized treatment and private rooms; larger institutions can support a broader range of vocational programs with less costly custodial supervision.

The Dual System in Operation

Differences Caused by Scale

Prison systems reflect scale disparities in two ways: Women's institutions have smaller populations (In 12 of the 15 sample States, the one women's facility has a smaller inmate population than *any* of the male institutions in the State); also there are fewer, and by necessity more widely separated, institutions for women. The 1971 *ACA Directory* lists approximately 40 State institutions for women, approximately 250 for men. Similarly, there are three Federal institutions for adult women, 23 for men. These factors have generated a variety of treatment differentials, particularly with regard to the remoteness of each institution, the heterogeneity of its population, and the level of its institutional services.

Remoteness—The relatively small number of women's prisons results in what might be termed a "remoteness" disadvantage. Eight States (Idaho, New Hampshire, Rhode Island, Vermont, Montana, North Dakota, Wyoming, and Hawaii) do not maintain any institution for the incarceration of women felons; these States consider it uneconomical to provide facilities for their relatively small female felon populations and instead make arrangements with neighboring States to "board" them. Remoteness is also significant in those States which have more than one male institution and incarcerate men in the institution nearest their homes. No State, however, operates more than one institution for the incarceration of women.

Some administrators contend that remoteness of women's institutions is not completely disadvantageous; isolation can provide an opportunity for reorientation away from the inmate's former environment. But most administrators and incarcerated women agree that remoteness causes the woman inmate to experience greater difficulty in keeping track of her family or possessions, in communicating with her lawyer during any postconviction legal action, and in gaining access to her parole board. She may also be reluctant to participate in a work- or study-release program, knowing that she will probably be unable to continue once she is released and returns to her home.

Heterogeneity—Male prisons are "classified," with different institutions for different categories of offender. By contrast, each State's one female prison must be responsible for the entire range of female felons and frequently misdemeanants as well. Thus, in most States, the inmate population at the female institution is diverse in terms of offense, sentence, and age; this heterogeneity affects prison programs, security arrangements, and administrative policies.

In the Federal system there is a slight attempt to classify female offenders among different institutions. The common observation, however, is that greater classification would be preferable, particularly where the young or first offenders are concerned. The inmates themselves agree, claiming that women's institutions are more effective as schools for crime than rehabilitative centers.

Institutional services—Two examples of the scale variations in the level of institutional services between male and female institutions are medical and religious services.

Male institutions are more likely to have complete hospital and dental facilities than female institutions; women inmates are more likely to go into the community for medical care. In some States, where the female institution is near a male institution, medical facilities are shared.

Male prisons are also more likely to have full-time chaplains and occasionally even denominational variety in the available clergy. By contrast, part-time and visiting chaplains typically provide the only formal religious services available in a woman's institution —a significant disadvantage since chaplains are often an important source of counseling and a moving force behind prison reform. Again, it should be noted that female institutions which are close to male institutions often receive more than the normal allotment of clergy.

Differences Influenced by Stereotyping

Many of the important differences between male and female prisons are generated in part by legislative and administrative sexual stereotyping.

Such differential treatment is found in physical surroundings, recreational facilities, institutional staff, and rehabilitative and industrial programs.

Physical environment—The architecture and security arrangements of women's prisons suggest a greater emphasis on rehabilitation and a lesser concern with custody than those of men's prisons; gun towers, double fences, and concrete walls are rare in women's institutions. Many of the campus or cottage type, with dormitory, vocational training, and dining buildings grouped around a central yard even seem bucolic.

The interiors of women's prisons also reflect the societal judgment that female inmates require more privacy and individuality, but less security relative to each other and the outside world. For example, women's sleeping quarters are usually private rooms rather than the multibed barracks or multitiered cellblocks typical of male facilities. When men are given individual cells, the explanation is the security needs of the institution rather than the privacy needs of the prisoner. Reflecting a similar concern for privacy, women's toilets and shower facilities are usually partitioned, unlike the open latrines and communal showers of most male institutions.

Prison rules frequently reflect the same stereotypes: Women may choose their own bedspreads, furniture covers, and curtains. Men are not thought to require a "homelike" atmosphere. Furthermore, inmate uniforms, which are almost universally mandated in men's prisons, are not typically required in women's institutions—explained by the greater importance of personal appearance to women.

Recreational facilities—Male inmates usually have better recreational facilities. Female institutions seldom have playing fields, and there is apt to be less variety in the recreational programs. In justfying such disparities, administrators stress perceived differences in the recreational needs of men and women, stating women inmates "just don't need the sort of physical exertion that men do."

In several States, however, women inmates enjoy at least one recreational advantage: They are allowed to make more trips outside the prison—for movies, bowling, swimming, and athletic events—than are their male counterparts. This advantage accrues because they are perceived to be less dangerous and escape-prone, and because such trips are much easier to manage with the typically smaller female populations.

Institutional staff—The staff at men's and women's prisons differ both in number and in their relationship to the inmate populations. First, there tend to be more staff members per inmate in female institutions. An even greater disparity appears when the statistics on "treatment" personnel (teachers, vocational instructors, counselors) are compared. While the higher staff/inmate ratios at women's prisons are most often viewed as advantageous, inmates at some female institutions complain that the more numerous staff infringe on their privacy.

Different staff-inmate relationships characterize men's and women's prisons: Administrators at female institutions describe the relationship as "mother-daughter," whereas the staff in male prisons tend to be more concerned with rules and order. The staff at male prisons are more likely to wear uniforms.

An additional factor bearing on staff-inmate relationships is the greater sexual integration of the staffs of female institutions. Women's prisons have had some staff integration, with

male correctional officers assigned for security reasons. Because of the stereotype of male prisoners as more dangerous, however, female correctional officers were rarely assigned to male institutions. Recently, the administrators of several female institutions have felt that the institutional atmosphere is more "natural" when members of both sexes are present as correctional officials, but male institutions are still far behind in the process of integration.

Educational and vocational programs—There are some differences in the academic education available to male and female offenders, although they are not as consistent or severe as those in other treatment areas. Differences in academic education generally stem from factors of scale and tend to disadvantage female inmates. Frequently, a particular program will not be offered at the female institution but will be available at some of the State's male prisons.

Substantial differences are also found in prison teaching staffs: Women's prisons tend to have fewer teachers, but better teacher/inmate ratios. Thus, while the larger number of teachers in men's prisons permits specialization by both grade level and subject matter, the better teacher/inmate ratio in women's prisons may permit more individual attention and assistance.

The influence of sexual stereotypes creates a much greater disparity in vocational training. Male prisons consistently offer a far greater variety of vocational programs. This disadvantage for women is compounded by the fact that male inmates are often assigned to a particular institution on the basis of their vocational needs. Even the larger female institutions do not have more than two or three programs, and the nature of the programs that are offered attest to the influence of sex stereotypes. For instance, one women's institution cites, "Because a large proportion of residents in the institution will be paroled to their homes as homemakers, and do not necessarily plan to pursue employment careers, the curriculum is designed to include training which will improve their qualifications as homemakers and also provide a cultural enrichment opportunity. . . . For those who do propose to follow careers in the work world, the small population of the institution makes it difficult to provide a wide range of vocational courses."

Industrial programs—Although both male and female prisons typically have some industry, men again enjoy a considerable advantage in both number and variety. These differences are partially a function of scale, but the relative number of programs available in female institutions is too small to be explained by scale alone. Moreover, those programs that are offered reflect general societal stereotypes concerning appropriate work for women.

The Fourteenth Amendment: Modification of the Dual System

The differential treatment of men and women inmates is permissible under the Fourteenth Amendment. Although the Supreme Court has never explicitly considered the issue, its decisions in other women's rights cases suggest that most of the sexual classifications in prisons today do not violate constitutional standards.

The Rational Basis Test

In *State* v. *Heitman*, the Kansas Supreme Court considered at some length the legal and penological basis for sexual differentials in corrections. The *Heitman* court argued that since men and women differ physically and

psychologically, and therefore require different correctional facilities and programs, the rationality of sexual classifications was "obvious." When the next sexual correctional classifications challenges reached the courts in the late sixties, the *Heitman* rationale still seemed to control, and the differential treatment of men and women within prisons has yet to be held unconstitutional by any court.

Emergence of a Stricter Standard of Review

Since 1968, several State and lower Federal courts have entertained successful challenges to differential sentencing schemes. The two leading cases, *Commonwealth* v. *Daniel* and *United States* v. *York*, suggest a stricter standard of review which might be applicable to all sexual classifications in criminal corrections.

In *Daniel*, the Pennsylvania Supreme Court invalidated a statute which required a judge, in the case of female offenders only, to fix an indeterminate sentence at the statutory maximum for the particular offense. The statute under attack in *Daniel* embodied the arguably rational judgment that women respond better to individualized institutions or sentences, yet the *Daniel* court required a more rational approach to classification by sex than did the *Heitman* court.

In *York*, a Federal district court went even further in invalidating Connecticut's differential sentencing scheme. It required the State to show that its classification was reasonable in light of its purposes, and this Connecticut was unable to do: It could not demonstrate that women required longer periods of incarceration, nor could it show that there was actually a difference in the "quality of treatment and conditions of incarceration" at the women's facility.

The combination of a marginally suspect sex classification, bolstered by an unwillingness to accept the grosser sexual stereotypes seems to have produced a more "active" rational basis test. Such a test asks for substantial and empirically grounded justifications which seem reasonable and which are narrowly drawn to reflect the relevant differences between men and women.

Application of the Intermediate Standard of Review

There are some treatment differentials which even a relatively permissive standard of review would invalidate: A substantial disparity in the basic necessities would be unconstitutional. Those treatment differentials which do have an arguably rational basis might still be invalidated under an "intermediate" standard of review.

Segregated institutions—No court has ever suggested that sexually segregated prison facilities are unconstitutional. An intermediate standard would require substantial justification for the maintenance of segregated institutions. The State might assert its interest in preserving order within prison facilities: Male competition for the attentions of so few women inmates might be a source of tension, if not violence. Though security interests have been held to be insufficient to justify the maintenance of racially segregated prison facilities, the new Federal experiment with a partially integrated prison may undercut the claim that sexual integration leads to violence.

The State might also argue that administrative efficiency justifies segregation, or the State might assert its interest in the rehabilitation of the female inmate population. If the relatively small number of women prisoners in any one State were divided among the men's institutions, leaving

a handful within each all-male institution, the resulting lack of female companionship and male orientation of prison programs would be detrimental to the comfort and rehabilitation of the women prisoners.

Courts have approved such considerations unless the facilities available to one sex are markedly inferior. Thus, the inference that separation denotes inferiority does not apply in sexual segregation cases and a "separate but equal" system appears to be permissible under the Fourteenth Amendment.

The remoteness-heterogeneity dilemma—Women's prisons are too few in number to permit incarceration near the inmate's home and are too small to permit significant internal classification. The only satisfactory method of eliminating such disadvantages—short of sexual integration—would be to construct small, local women's institutions in each State equal in number and variety to that of the State's male system. However, few courts would order a State to expend the millions necessary to provide a full range of correctional institutions for women.

Rehabilitative programs and personal services—The "separate but equal" argument will not be successful unless there *is* true equality. Yet, the State interest in fiscal economy would bar the complete equalization of services and programs.

It is unlikely that any disparity in the provision of medical or religious services could be justified. A severe disparity in treatment personnel and programs would probably be unconstitutional, unless the State could affirmatively establish that women have less need for such programs. The courts might allow a defense that the types of vocational and industrial programs offered should reflect the work preferences and realistic job opportunities that sexual stereotypes have engendered in the inmates and society as a whole.

The precedents in this area suggest the parameters of the problem. On the one hand, the courts have traditionally granted the State broad discretion in allocating rehabilitative programs among its various institutions. The availability of some programs at some facilities does not appear to produce an obligation to offer them to all prisoners. On the other hand, such institutional differentiation has been viewed with closer scrutiny when the classification was sexual in nature. In *Dawson* v. *Carberry*, female inmates of the San Francisco jail sued to join a work-furlough program from which they had been excluded. A Federal district court ordered the women included, rejecting the State's argument that it lacked the resources to build comparable female facilities and that the small number of women did not justify such an expendidture in any event.

However, despite *Dawson*, the precedents suggest that an equal protection challenge must be directed not to the absence or inadequacy of any one program, but rather to the overall inferiority of the programs and services at the female prison. The principle enunciated is that the sexes may be segregated, but that separate must be equal.

The Equal Rights Amendment: Elimination of the Dual System

Although there is some possibility of reform under the Fourteenth Amendment, any substantial movement toward the equal treatment of men and women in correctional institutions must await ratification of the proposed "Equal Rights" Amendment, which requires that:

Equality of rights under the law

shall not be denied or abridged by the United States or by any State on account of sex.

Interpretation of the Amendment

The absolute approach—The language of the Equal Rights Amendment may be interpreted in three different ways: that any sexual classification must rest on some "rational" basis; that any such classification must be justified by some compelling State interest; or that no State interest, no matter how compelling, can justify a sexual classification.

As noted above, the first two interpretations are tests the courts now apply under the Fourteenth Amendment. The third view holds that the law must deal with the individual attributes of the particular person rather than make any broad sexual classifications. Differentiation on account of sex is thus totally precluded, regardless of whether it is "reasonable," beneficial, or justified by "compelling reasons."

The ERA's legislative history clearly indicates that Congress adopted this third, absolute interpretation. The "rational basis" test was repeatedly rejected as providing an inadequate check on sexual discrimination. Similarly, while Congress never explicitly rejected the "compelling State interest" test, it did so implicitly through its clear support for the absolute interpretation—the fundamental proposition that sex should not be a factor in determining the legal rights of women or of men.

Exceptions—Certain exceptions are accommodated by the ERA. Under one interpretation, the Amendment would not prohibit legislation dealing with physical characteristics unique to one sex. This is permitted because it does not deny equal rights to the other sex, is limited to *physical* characteristics, and does not extend to psychological differences, since the latter cannot be said with any assurance to be truly unique to one sex. This exception is to be strictly limited to situations where the legislation is directly and narrowly related to the characteristics in question.

This interpretation also recognizes that the ERA must be harmonized with other provisions of the Constitution. Two existing constitutional rights are of special significance to the operation of prisons: the right of privacy and the prohibition against cruel and unusual punishment. Congress clearly passed the Amendment in the belief that it would be balanced against the right of privacy, and that as a result the sleeping and toilet facilities of public institutions could continue to be sexually segregated. This conclusion is by no means self-evident, although the right of an inmate to disrobe and perform personal functions out of the presence of inmates of the opposite sex is probably inferrable from the reasoning of earlier privacy and prisoners' rights cases, at least where no legitimate security or rehabilitative interests dictate to the contrary.

The courts have held that prisoners have an Eighth Amendment right to be free from physical abuse at the hands of both State officials and fellow prisoners. The duty of prison officials is to minimize violence among inmates. Such constitutional principles must also be accommodated within the framework of the ERA.

Problems of Application

Would "separate but equal" treatment be permitted under the ERA?—In *Brown* v. *Board of Education*, the Supreme Court invalidated the doctrine of "separate but equal" in the racial context on the grounds that separate, by its very nature, could not

be equal. Existing evidence tends to show that sexually separate facilities are rarely equal. There is evidence that the Congress, by its refusal to revise the ERA, intended that the Amendment would require sexual integration of all public institutions, including prisons. The constitutional exceptions described above would not bar such integration: Privacy does not require the segregation of entire institutions, and the right to be secure from physical abuse can also be accommodated in far less drastic ways.

Equalization—Having established that integrated facilities would be required by the ERA, the question becomes whether the conditions of the integrated facilities would reflect an equalization up to or down from the best of the present institutions. As a matter of constitutional law, the courts, when dealing with an underinclusive discriminatory law or practice, can select either remedy.

Under the ERA, Congress states that "those laws which provide a meaningful protection would be expanded to include both men and women." A similar procedure has already been required in the areas of employment discrimination and the equalization of other personal benefits. In the prison context, if men are found to be receiving special benefits or better treatment, it seems clear that the proper remedy would be to extend those benefits to all inmates, including the relatively few women, in the new coeducational institutions. But the converse situation is somewhat more difficult: An extension of benefits now enjoyed by the female inmate population to the larger male population might put an enormous economic burden on the States, which the courts would not mandate. Since the ERA would require a program of equalization, the States and the courts would have to compromise in adapting the old male prisons to the needs of coeducation, equalizing up where feasible and down where necessary. The "better" female institutions would still be available to be used as minimum security facilities for inmates of both sexes.

The Sexually Integrated Institution

Ratification of the ERA would require changes in many aspects of prison life and administration. Treatment differences resulting from economies of scale would be eliminated automatically by the integration of the institutions. For example, men and women would have equal access to the medical facilities and religious programs provided at a particular institution. The problem of remoteness would be similarly eliminated. Many other problems, however, would not be solved by the simple act of integration.

The classification process—Where a State maintains only one institution for all male offenders and none for its female felons, the process of integration would be relatively straightforward: All offenders would be housed in one institution. However, in those States where different institutions are presently set aside for different categories of male offenders, the classification process would have to be revised to accommodate women on an equal basis. The ERA would require that the classification standards employed be objective and sexually neutral in both application and effect.

There is some danger that application of such a sexually neutral scheme would result in grossly unequal treatment for some women. For example, a female inmate might find herself one of only two or three women in an "integrated" population with hundreds of men. Such gross numerical disparity

may run afoul of the Eighth Amendment prohibition against cruel and unusual punishment, the inmate's right of privacy, and her right to equal protection of the laws. In such a situation, the courts might allow a woman to choose not to be confined in a particular institution. Incarcerating five or ten women in each institution should provide sufficient same-sex companionship without significantly hindering the process of integration.

The physical environment—Most women now receive better treatment than their male counterparts. The ERA would eliminate this differential by subjecting both men and women to the same physical surroundings in sexually integrated institutions. Ideally, the equalization would be up to the level enjoyed by women. But in most States, this would require either renovation of almost all existing male institutions or the construction of all new facilities designed to meet the high standards now found in most female prisons. If the State faces an economic roadblock to equalizing up, the ERA would tolerate equalization down to a lower, more economically feasible level.

Sexual integration need not result in heterosexual cohabitation, since the constitutional right to individual privacy would require provision of sexually separate facilities for disrobing, sleeping, and performing personal functions. Although constitutional requirements are not precisely defined, a State would probably be permitted to look to "societal mores" in interpreting the right of privacy in public institutions.

Rehabilitation—Under the ERA, the current disparity in both the quantity and quality of rehabilitative programs available to men and women would have to be eliminated. Such equalization should create no significant economic costs. Every State institution is not required to offer identical rehabilitative programs, but rather that equal access to all programs within that institution be provided. Assignments to prison industries and other work details would also have to be made on a sexually neutral basis.

Patterns of sexual discrimination exist throughout the prison systems of the United States. Every State exhibits differences related to both scale and sexual stereotypes in the treatment of its male and female offenders. Discrimination varies, but substantial discrimination against both men and women is widespread.

The Fourteenth Amendment has had little impact on the elimination of sexual discrimination. But ratification of the proposed Equal Rights Amendment should require that, within certain constitutional limitations, the nation's prisons be integrated so as to insure equality of treatment for both men and women inmates.

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Token and Taboo: Behavior Modification, Token Economies, and the Law

David B. Wexler

Commentators and authorities have recently directed attention to important procedural problems in the administration of psychiatric justice and to the legal issues presented by various methods of therapy. Legal restrictions on a hospital's right to subject unwilling patients to electroconvulsive therapy and psychosurgery are developing rapidly, and scrutiny is now being given to "aversive" techniques of behavior modification and control—such as procedures for suppressing transvestitism by administering painful electric shocks to the patient while dressed in women's clothing, and procedures for controlling alcoholism or narcotics addiction by arranging medically for severe nausea or even temporary paralysis (including respiratory arrest) to follow ingestion of the habituating substance. It is likely that certain treatments may be deemed so offensive, frightening, or risky that the law may eventually preclude them altogether, or restrict them by requiring the patient's informed consent.

Though aversive therapeutic techniques are receiving close attention, schemes of "positive" behavior control —whereby appropriate, nondeviant behavioral responses are encouraged by rewarding their occurrence—have not been subjected to careful study. It is perhaps assumed that when rewards rather than punishments are employed, no grave legal, social, or ethical questions are involved. To a great extent, that is true: Few would have their ire aroused, for example, by praising a child and offering him candy for correctly spelling or reading a word, nor would many be upset over a scheme that encouraged scholastic achievement of institutionalized juvenile delinquents by offering them, contingent upon academic success, private rooms, a wider choice of food, and selections of items from a mail-order catalog. But many techniques of positive control are more troubling. Most troubling seem to be the use of token economies with chronic psychotic mental patients.

Psychology and Token Economies

Many behavior modification practitioners apply clinically the learning theory principles of Skinnerian operant conditioning.

The application of operant conditioning to humans has come a long way since 1949, when a severely regressed person was taught to raise his arm by a procedure that rewarded appropriate arm motions by the subsequent squirting of a sugar-milk solution into his mouth. Now, a multitude of therapeutic behavior modification systems are in operation on wardwide and institutionwide scales. These programs seek to shape and maintain appropriate behavior patterns—designated as "target behaviors" or "target responses"—by rewarding or "reinforcing" the desired responses. Usually, rewards are dispensed in the form of tokens or points—known as "secondary" or "generalized" reinforcers—which can then be converted, pursuant to a specific economic schedule, to "primary reinforcers" such as snacks, mail-order catalog items, and the like.

These "token economies" are currently employed in a variety of clinical settings. This article will be confined to a discussion of the application of the token system to chronic psychotics.

There are two reasons for this limitation: First, despite advances in psychopharmacology and a burgeoning community psychiatry movement which have combined to reduce drastically mental hospital enrollment, almost all chronic psychotics are still hospitalized. If other clinical categories are diverted from institutions while the chronics continue to accumulate, the treatment of the chronic psychotic may constitute the major therapeutic concern of mental hospitals. Second, because the behavior patterns of chronic psychotics are by definition particularly resistant to therapy, more drastic methods of behavior modification have been applied to them. These therapeutic methods will raise important legal questions.

Token economies—Teodoro Ayllon and Nathan Azrin pioneered the token economy concept on a ward of chronically psychotic female patients at the Anna State Hospital in Illinois. Because of their adaptation to long periods of stagnant hospitalization, chronic patients typically suffer from extreme apathy and dependency. This condition, known as institutionalization, impedes the chronic's chances for improvement or release. To overcome this problem, Ayllon and Azrin rewarded target behaviors that would reverse the institutionalization syndrome. Work assignments within the hospital and various self-care behaviors were rewarded with tokens. The self-care category included grooming, bathing, toothbrushing, bedmaking, and the like. Work assignments included kitchen chores, serving in the dining room, assisting in the laundry, janitorial work, and related tasks.

For the token economy to succeed, it is necessary to insure that the items or events purchasable with the tokens are effective reinforcers—that they would in fact be desired by the patients. To solve this problem, the psychologists have applied the "Premack Principle": If certain behaviors occur naturally with a high frequency, then the opportunity to engage in those behaviors can be used as an effective reinforcer to strength low-frequency behaviors empirically. In the Ayllon and Azrin study the following items were determined to be potentially effective reinforcers: personal cabinets, room dividers, visits with the professional staff, ground privileges, supervised walks, and religious services. All were made contingently available to the patients: They could be purchased if the patient had performed a sufficient number of target responses to have earned the requisite tokens to purchase the reinforcers. They were otherwise unavailable. Other reinforcers included a personal chair, writing materials and stationery, movies, television programs, and various commissary items.

By using these sources of motivation, the token economy produced impressive results when measured by standards of work performance. Comparing the work output of their patients during a specified period of the token economy with a subsequent experimental period during which the various reinforcers were freely available without tokens—a situation which "approximated the usual conduct of a mental hospital ward." Patient performance during the experimental period plummeted to less than one-fourth the token economy level. Hence, they concluded that "the performance on a usual ward would be increased fourfold by instituting this motivating environment."

Nonetheless, the Anna State Hospital program did not change the behavior of 8 out of the 44 patients involved. The eight patients, who expended fewer than 50 tokens within

20 days (all earned by self-care rather than from job assignments) were relatively unaffected by the reinforcement procedure. It appears that their failure to modify behavior appreciably was attributed to the relative absence of any strong behavior patterns that could be used as reinforcers. The only two behaviors that existed in strength among the eight patients were sleeping and eating. Controlling the availability of food may have to be considered in future research in order to rehabilitate patients with such an extreme loss of behavior.

Many token economy programs have been patterned after the Ayllon and Azrin model. In a Veterans Administration Hospital, patients earned points for industrial therapy job assignments, for participating in group activities and recreational therapy, and for attending weekend movies. And reinforcers in various programs include later wake-up times, passes, clothing, clothing maintenance, reading materials, dances, and even release. Moreover, several programs have made food and beds available only on a contingent basis.

One of the token economies that hinges food and beds on appropriate behavioral responses—a chronic ward at the Patton State Hospital in San Bernardino, California—is "willing to let a patient go for as long as 5 days without food, or until he has been reduced to 80 percent of his previous body weight. The Patton program is one of several token economies that follows a "phase" or "tier" system, where at least certain privileges are dependent upon the patient's place in the hierarchy of tiers.

At Patton, for example, newly admitted patients are placed in the orientation group, where living conditions are drab and where the subsistence-level existence can be purchased for a small number of tokens. After a patient has adapted to the orientation group, he is elevated to the middle group, where conditions are better but are considerably more expensive. Patients in the middle group are given 5 months to be promoted to the rather luxurious ready-to-leave group, but if after 3 months in the middle group a patient is not adequately facing the eventual prospect of life on the outside, he will be returned to the orientation group.

Before leaving a description of token economies, it will be instructive to discuss a token environment established at the Richmond State Hospital in Indiana.

Prior to the inception of the token economy, legally committed alcoholics at Richmond State were first admitted to the Receiving Unit, where they were provided with rest and medical care. Within 1 or 2 weeks the patient was usually assigned to an open ward, with a work assignment within the hospital and all the available privileges. When the token system was introduced, certain alcoholic patients without intellectual, organic, or psychotic impairments were inducted into the program. Work in the hospital labor force, compensated by points, was deemed the target behavior. The reinforcers included a broad range of patient needs and privileges—for example, room and board, clothing maintenance, canteen purchases, Alcoholics Anonymous meetings, short leaves of absence, disulfiram treatment, different kinds of psychotherapy, and special instruction.

Points were also needed to purchase advancement through the five tier system used at Richmond. The five tiers consisted of two closed wards, a semiclosed ward where ground privileges were available by purchase, and two open wards with pass privileges.

Patients could purchase promotion only at weekly intervals.

The program was considered aversive by prospective members, as well as by the inducted members who requested weekly group meetings which became grievance sessions. Grievances were in part attributable to the situation established by starting patients in a closed ward of low status, substandard comfort, and curtailed freedom, relative to other wards in the hospital.

Law and Token Economics

To speak of a specific "law of token economies" is out of the question, for at this date there is scarcely a handful of statutory and judicial pronouncements dealing even generally with the rights of the institutionalized mentally ill. Until recently, the judicially manufactured "hands-off" doctrine enabled the courts to duck important questions regarding the limits of administrative discretion in the operation of prisons and mental institutions. Accordingly, the correctional and therapeutic establishments were in effect given, by default, the legal nod to manage their institutions—and to conduct their therapy—as they saw fit. But the last few years have witnessed a remarkable turnabout in the willingness of courts to scrutinize living conditions in institutions. Already, some far-reaching decisions have been rendered. There is the further possibility of widespread legislative action, and the emerging law bears directly on the rights of patients subjected to a token economy.

The encouragement of certain target responses—such as proper personal hygiene and self-care—surely seems beyond legal question, but it will be recalled that the principal target response of most token economies is adequate functioning on an institutional work assignment. Many persons both within and without the legal profession, however, find it objectionable in effect to require patients—especially involuntarily committed patients—to work for mental institutions, particularly without standard compensation. Though the work assignments are often cast in therapeutic terms, the critics view the jobs as laborsaving devices which exploit patients. That patient job assignments are in fact often laborsaving is beyond question, as is the fact that work output will increase substantially when work is contingently reinforced by the standard reinforcers employed by token economies.

The law will not tolerate forced patient labor that is devoid of therapeutic purpose and which is required solely as a laborsaving technique. But recognition that there is not always a sharp line dividing therapeutic and nontherapeutic assignments has led to varying legal theories for dealing with —or for avoiding—the problem.

One rule of thumb is suggested by a leading mental health lawyer: If a given type of labor is therapeutic, patients in private facilities would be performing that type of labor. Conversely, labor not generally performed in private facilities might be cost-saving rather than therapeutic.

In *Wyatt* v. *Stickney*, the court barred all involuntary patient labor involving hospital operation and maintenance, but permitted voluntary institutional work of either a therapeutic or a nontherapeutic nature, so long as the labor was compensated pursuant to the Federal minimum wage law. The *Wyatt* court specified further that hospital privileges or release shall not be conditioned upon the performance of labor involving hospital maintenance.

The approach taken by the landmark *Wyatt* decision would have an immense impact on traditional token economies. Patients could not be

forced to perform institutional labor assignments—and the force could not be exerted indirectly by making reinforcers "contingent" upon appropriate performance. Further, if patients should decide voluntarily to undertake institutional tasks, the minimum wage is the legally required "reinforcer." Perhaps most significant for token economies, *Wyatt* and related legal developments seem to have a great deal to say regarding the definition of legally acceptable reinforcers. *Wyatt*, together with an occasional piece of legislation, has begun the process of enumerating the rights guaranteed to hospitalized mental patients. The crux of the problem, from the viewpoint of behavior modification, is that the items and activities that are emerging as absolute rights are the very same items and activities that the behavioral psychologists would employ as reinforcers—that is, as "contingent rights." According to the *Wyatt* court these rights include provisions relevant to personal belongings and comfort, privacy, diet, exercise, recreation, and interaction with other patients and visitors. The judge recognized patients' rights to the least restrictive conditions necessary to achieve the purposes of commitment—presumably including, if clinically acceptable, ground privileges and an open ward. Thus, the usual target behaviors for token economies would be disallowed and the usual reinforcers will be legally unavailable.

The *Wyatt* case is consistent with the trend of legal thought that bears on traditional tactics for the behavior modification of chronically psychotic behavior. Therefore, it is important to examine particulars of the psycholegal conflict and their implications and to point to a path for future legal and therapeutic development.

Analysis and Implications

The important question of the therapeutic or nontherapeutic nature of institutional labor is more complex than would be indicated by the treatment it has received from both legal and psychological quarters. For instance, the notion that types of patient labor performed at public, but not at private hospitals, should be presumed cost-saving rather than therapeutic is undermined by the clinical and socioeconomic differences between private and public hospital patients. Private hospital patients are typically skilled, of adequate means, and in the hospital for a short stay. Chronic psychotics at State institutions are usually persons who have been hospitalized and unemployed for long periods of time; they are poor, unskilled, often of advanced age, and likely to suffer considerable stigmatization upon release from the hospital.

Given this characterization of chronic mental patients—combined with apathy, dependency, and institutionalization—ambitious employment opportunities for released chronics are virtually out of the question. Considered with the fact that work of almost any kind is probably superior to idleness in offsetting apathy, a wide range of institutional work activities have both therapeutic value and realistically approximate future employment goals.

Evidence that the motivation behind establishing target behaviors is therapeutic rather than simply cost-saving can be gleaned from several facts and from examples where cost-saving was not in issue. One Veterans Administration program for discharged chronics, for instance, provides patients with token-earning formal classes in shopping, washing, ironing and mending clothing, and related

tasks. Moreover, in one instance where released chronics managed to adjust successfully to a form of community life and to remain employed, the nature of the employment was perfectly consistent with training provided by standard institutional tasks.

Apparently many forms of institutional labor, even though concededly cost-saving, prevent apathy and prepare patients for life on the outside. If the performance of therapeutic institutional labor by patients is to be encouraged, however, safeguards should insure that no patient becomes indispensable to his supervisor, a possibility that might result in the patient's continuation on the job becoming more important to the staff than his welfare, his treatment, or even his discharge.

If, given certain safeguards, voluntary institutional labor by chronic patients is to be encouraged, *Wyatt's* minimum wage mandate might cause serious complications. First, it will divert appropriations away from other hospital and therapeutic uses. Second, a minimum wage requirement may encourage the hospital to fill its institutional positions with permanent outsiders instead of with patients, perhaps leaving the patients to pursue less therapeutic activities. In other words, a minimum wage requirement may possibly result in greater expenditures for less effective therapy.

It is clear, however, that various safeguards short of the minimum wage can be invoked to prevent patient peonage, and that voluntary patient labor can probably be encouaged either by monetary rewards somewhat below the minimum wage or by whatever other reinforcers satisfy the *Wyatt* test.

But in many respects the work and wage question is secondary to the question of legally acceptable and psychologically effective reinforcers. The major problem faced by the token economy is the current trend toward expansion of the category of protected inmate interests. The law, relying on concepts such as freedom and dignity, would require, for example, that all patients be accorded minimal levels of privacy and comfort. But the behavioral psychologist views privacy or comfort as useful tools which he can manipulate to make a psychotic's behavior more appropriate and socially adaptive—a goal which presumbaly all agree is in the best interest of both the patient and the society. In the psychologist's view it would surely be an ironic tragedy if, in the name of an illusory ideal such as freedom, the law were to deny the therapist the only effective tools he has to restore the chronic psychotic to his health—and his place in the community.

Wyatt thus poses a painful dilemma. The behavior modifier suggests that chronic psychotics respond initially to only the most primitive reinforcers. If the basics are made freely available as rights rather than as reinforcers, chronic psychotics may be destined to spend their lives functioning poorly in an institutional setting, whereas if those basic rights are converted into contingent reinforcers, there may be a prospect of clinical improvement and discharge.

If the empirical evidence supported the claim that token economies relying on primitive reinforcers worked very well with chronic patients—that, for example, virtually all patients improved dramatically and were able to earn the reinforcers required for a decent existence or if the evidence demonstrated that no less drastic means could accomplish similar results —a reevaluation of the emerging law might very well be in order. But behavior modification proponents may have difficulty sustaining a burden of

proof with respect to those matters.

First of all, while most token economy outcome studies report favorable results, the successes are far from overwhelming, and when judged by release data rather than by measures of work output, decreased apathy, or improved clinical state, results of token economy systems with chronic psychotics have not been encouraging.

We must also consider whether the results achieved by token economies could be matched or surpassed by less drastic means. Information is wanting, perhaps in part because behavior modifiers have not employed reinforcers other than the basics in standard use. By exploring creatively for reinforcers, it is likely that therapists could construct a list of idiosyncratic objects and activities that could be made available contingently in order to strengthen appropriate target responses. Moreover, to the extent that effective reinforcers are idiosyncratic, it follows that their contingent availability could not conflict with the legally emerging absolute general rights of patients.

A system of positive behavior modification based heavily on idiosyncratic reinforcers might be clinically as well as legally superior in that each patient is assured of independent diagnostic and therapeutic attention. Such individualized treatment plans, required by *Wyatt* and perhaps part of the emerging right to treatment, are not incompatible with the operation of general treatment systems designed to overcome patient problems such as indecisiveness, dependency, or apathy. In fact, the most fruitful combination might be to combine individualized treatment programs with an efficient general therapeutic system. If, however, the criteria for a successful system is efficacy with the least drastic deprivations possible, token economies for chronic psychotics may finish second best.

The work of George Fairweather is highly relevant here. Though he speaks the language of social psychology and of small group theory, Fairweather relies in part on principles of behavior modification. But his study was bottomed on the belief that chronics, to survive outside, must acquire problem-solving and decisionmaking skills, and on the knowledge that small cohesive groups can effectively control the behavior of their members. Patients were divided into small task groups with monetary and pass privileges awarded according to the level of responsibility each individual attained. The amounts of money and number of passes were set up in advance for each of four progressive levels of achievement. The task group as a unit became responsible for the progress of its individual members through the four designated steps. Step 1 involved personal care, punctuality on assignments, and cooperation in the orientation of new members. Step 2 required, in addition, acceptable work on the job assignment. Requirements in Step 3 were individualized, with patients responsible for recommending the level of their own rewards. In Step 4 the patient had responsibility for his departure plans, and had unlimited rights to withdrawal of money and passes. In Step 1 the patient received $10 and a 1-day pass each week; in Step 2 he received $15 per week and an overnight pass every other week.

The task group was responsible for dealing with patient problems and for recommending to the staff the level of pass and monetary privileges deserved by each patient member. At times the group as a unit would be advanced or demoted.

Over time pride in group achievement appeared to become a more im-

portant motivator than money or passes. Leaders emerged in the groups, and the program was a therapeutic success: As compared with a control group subjected to traditional hospital therapy (not a token economy), the small-group patients showed significantly less pathological behavior, greater social interaction, and greater participation during meetings. Moreover, the small group program substantially reduced hospitalization. When combined with an aftercare program involving a voluntary living arrangement in a community lodge, the Fairweather system achieved the long-awaited goal of adequate employment and community adjustment for discharged chronic psychotics. Fairweather thus produced impressive results with chronic psychotics in an environment clearly "less drastic" in deprivation than any of the traditional token economies.

Fairweather's approach, then, seems preferable to token economies on several counts. First and foremost, his small group system has yielded impressive results which are unmatched by token systems. Second, while token systems deprive patients of basic comforts in their reliance on primitive reinforcers, Fairweather employs only money and passes. Third, Fairweather's approach is thoroughly oriented toward release and community adjustment, and he recognizes that once cohesive groups have been formed in the hospital, "an immediate move to the community is essential." Finally, Fairweather's behavior modification model emphasizes the development of confidence and decisionmaking ability rather than performance of assignments. This system may be ethically or at least emotionally more palatable than the manipulative techniques of the token economies.

Fairweather's small group model, with its rich results and rather minor deprivations, poses a serious threat to token economies. If further studies continue to indicate that token economies for chronic psychotics resort to more drastic deprivations than other therapies without producing better results, it is likely that token systems will soon find themselves subject to both legal and behavioral extinction. Indeed, if the law's general direction in the patient rights area proceeds uninterrupted, token economies may well become legally unavailable even if they are therapeutically superior to other approaches.

Forcing these disparate disciplines to take note of each other should be helpful to both of them. Behavior modification proponents, convinced of the therapeutic indispensability of token economies for chronic patients, may have reservations about the Fairweather model. But unless systematic comparative studies of alternative therapies are performed soon, the law will be unable to incorporate the results in developing a sensible package of patient rights, and expected legal developments may ultimately preclude such studies.

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Mental Anguish as an Element of Damages in Malpractice Cases

James G. Zimmerly and Walter A. Oleniewski

In recent medical malpractice actions, claims for damages for alleged mental anguish have become more prominent, and the concept of mental anguish as an element of damage is undergoing a gradual transformation in our courts. Originally mental anguish was not recognized as an element of damages for which compensation could be allowed unless it was directly connected with a physical injury or was the direct result of an intentional wrong. Recovery for mental suffering was limited to a narrow area because it was felt that such a claim could easily be fabricated. If some physical impact could be shown, there was a valid foundation for determining its genuineness and the effect to an injured party. In some jurisdictions the courts have gone to unusual extremes to find evidence of physical impact in order to allow a party the opportunity to recover for mental suffering.

Mental anguish resulting from negligent medical treatment is an element of damages because pain or discomfort is easily found in most malpractice cases. When physical disability is shown, mental anguish has been accepted by the courts.

A brief sampling of decisions including damages for mental anguish in medical malpractice cases illustrates the breadth of the problem facing the medical profession. One plantiff was awarded $36,000 for the physical and mental anguish resulting from a laparotomy pad's being left in his abdomen. A gauze pack left in a woman's vagina entitled her to recover damages for humiliation and embarrassment. Another woman whose shoulder was burned by X-ray treatments for bursitis developed cancerphobia and recovered damages from the radiologists for her mental anguish. A Connecticut court rendered the plaintiff an award for mental anguish when he came down with arachnoiditis resulting from contrast medium being left in his spinal canal after a myelogram.

Humiliation caused by disfigurement is also compensable as a form of mental suffering. A 50-year-old woman was awarded $115,000 by a California jury in 1949 in a suit against a plastic surgeon for disfiguring her breasts and abdomen in an attempt to improve their appearance. A California hospital was liable for a female patient's mental anguish when she was intimately examined by 10 or 12 medical students over her protestations. After an unsuccessful sterilization operation, both parents were allowed to recover damages for their mental anguish when faced with an unwanted child. Each State has its own rule, but an increasing number of courts have regarded the physical consequences themselves or the circumstances of the incident as sufficient guarantee of mental disturbance, regardless of the presence or absence of physical impact.

Because the temporary emotions of fright are so easily counterfeited, courts have been hesitant in granting awards in instances in which the plaintiff's only claim is for mental anguish. Examples of this type of case involve claims against hospitals for giving mothers the wrong baby to take home. In such a situation, after the mistake was discovered and rectified, the parents were not allowed to recover

from the hospital for their mental distress. Nor were the parents allowed to recover if they were initially told the wrong sex of their baby. Such a suit may be successful if the plaintiff can prove that the defendant's actions were done with malice. In a recent California case, however, a mother who was given the wrong baby was awarded damages even though the error was corrected and she was given her own child within 5 to 7 hours. A jury accepted her claim of anxiety neurosis and resultant physical damage.

The State of Maryland has a Wrongful Death Statute which allows damages for mental anguish in the case of the death of a spouse or a minor child when the death was caused by the wrongful, negligent act or default of the defendant. The damages for mental anguish and emotional pain and suffering are in addition to the damages of pecuniary loss, loss of society and consortium, companionship, comfort, protection, marital care, parental or filial care, advice, counsel, training, guidance, or education.

In order for an injured person to recover damages for mental anguish, the plaintiff must have been conscious at the time of the injury and/or subsequent thereto. There can be no damages awarded for mental anguish in instances in which injury and death are instantaneous or in which the injured party never regains consciousness.

The plaintiff may testify as to his own mental suffering, and in certain instances the court may presume mental suffering from the nature of the claim, e.g., unauthorized autopsies or injuries resulting in the loss of sight or hearing. Psychiatric testimony may be necessary in those cases in which the plaintiff alleges an injury caused neurosis or psychosis.

Mental anguish concerning possible future disability is also compensable. *Gentile* v. *United States* involved a claim of anxiety neurosis caused by a lost catheter in the patient's circulatory system; the alleged negligent act resulted in a verdict of $92,500.

As courts become more receptive to the arguments of persons claiming mental anguish, the necessity of physical injury and physical impact will continue to be discarded in favor of a theory more concerned with the genuineness of the claim. The courts may grant claimants the same protections and remedies for mental injuries as are presently applied to physical injuries. Without looking for actual physical impact or attendant physical injuries, a court would concern itself with the effect on the plantiff's state of mind and the causal relationship between the defendant's act or omission and the mental anguish suffered by the plaintiff. Medical malpractice actions are one type of tort in which claims alleging mental anguish are becoming more common. As the general tort law changes with regard to damages allowed for mental anguish claims, we can expect to see these changes reflected in verdicts awarded in future malpractice cases.

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Black People and the Tyranny of American Law

Haywood Burns

In classical theories of democracy, the laws are supposed to reflect "the will of the people"—or at least of the majority. From the point of view of black people in this country, American law has been and continues to be racist in character. More than a century ago, Alexis de Tocqueville pointed out that in the absence of safeguards for the protection of minority rights, American democracy becomes just another form of tyranny. American blacks feel these safeguards either do not exist, or are not applied.

The law has been used as an instrument of constructive social change to the benefit of the blacks in the most recent past. However, etched deep in the collective consciousness of American blacks is the role that the law has played in their oppression. It is a present perception which comports with both the historical and contemporary reality.

The Past

Slavery—It is not often recalled that in the early 17th century white Europeans and black Africans existed side by side in various stages of unfreedom. Some form of bondage was a very common experience, and there was considerable confusion over the use of the term "slave" which was not synonymous with the word "Negro." Black persons served a term of years and were then released from service, some to own or hold other blacks in servitude.

However, throughout the 17th century the situations of the blacks in bondage and the whites in bondage diverged: The plight of the white steadily improved and that of the black became more debased. It was the law that was responsible for the crucial developments in this whole process by defining the perimeters of a slave system and permanently locking the black on the inside. This was accomplished by white men who, sitting in Colonial legislatures, passed laws making bondage for blacks a lifetime condition and a hereditary condition, marking the unborn, and condemning not an individual or a generation, but an entire people to slavery.

Nation building—With a revolution for liberty and the birth of a new nation, the more progressive founding fathers, those with scruples against slavery, were unprepared to tamper with private property and unable to accept fully the notion of blacks being their equals. Blacks were the victims of an American pragmatism that bartered and compromised their lives away in a process from which they had been totally excluded. Black school children of today look at the Constitution of 1789 and see enshrined in our fundamental law the guaranteed continuation of the slave trade, the required return of fugitive slaves, and the counting of enslaved, disfranchised blacks as three-fifths persons for purposes of political representation.

Pre-Civil War—It was the law, through the slave codes of the 18th and 19th centuries, which governed in oppressive detail the lives of millions of black slaves, denying a legal personality to blacks, barring them from bringing law suits or testifying against a white person. The slave codes regulated the movement of blacks, denied any family relationship, and applied criminal sanctions according to a different and harsher standard than ap-

plied to whites. The law confirmed and guaranteed the debased situation of the slave, and the entire legal apparatus was ultimately reinforced by the dictum, in the *Dred Scott* case, that the Negro "had no rights which the white man was bound to respect."

The oppressive role was not entirely a regional phenomenon—north of the Mason-Dixon line it was the law which relegated so-called free blacks to an inferior status, barring blacks from certain types of employment, banning them from within the borders of certain territories, requiring segregated schools, and withholding from blacks the franchise.

Post-Civil War—A Northern victory in the Civil War and the passage of the Thirteenth, Fourteenth, and Fifteenth Amendments were not sufficient to arrest this process, for immediately after the Civil War whites turned to the law to duplicate the vertical white-black relationship that existed prior to emancipation. Codes were designed to keep blacks close to the land, away from certain types of occupations, away from white women, and subservient.

After Reconstruction the law launched the strange career of Jim Crow, codifying the customs and usages of segregation and giving them universal application in the Southern States. It was the law, aided by community sanction, which created the grandfather clause, the literacy test, and the poll tax, disfranchising hundreds of thousands of blacks in the late 19th and early 20th century and stripping black people of the hard-won black political power. It was in this period as well that an increasingly conservative Supreme Court, giving narrower interpretations to the detriment of black people, rendered the *Plessy* v. *Ferguson* "separate, but equal" pronouncement. The citadel of legally established and sanctioned apartheid remained largely inviolate throughout most of the 20th century, until the U.S. Supreme Court decision of *Brown* v. *Board of Education* in 1954 and the Civil Rights Act of 1957—the first Federal civil rights legislation in the country since 1875.

The Present

The numerous successful legal attacks upon segregation have not solved the problem of racism and the law for black people today. Black lawyers, plaintiffs, defendants, and witnesses are still subjected to the overtly racist attitudes, actions, and comments of an overwhelmingly white justice system. Black people are affronted by a legal system that so often works against them and too seldom works for them when they have been victimized and when the State should be under an obligation to prosecute the white perpetrators of the wrong.

At one point in our history the law reserved exclusively for white men the right to sit on juries. Though jury statutes no longer state this exclusion, blacks are still excluded from juries through unfair procedures for compiling prospective jury rolls and through racial use of the peremptory challenge by the prosecutor. Black men and women have their liberty and property taken away and their lives put in jeopardy by juries from which their peers have been excluded.

In the 19th century there were legal provisions that prevented blacks from bringing law suits against whites, or from testifying when white interests were involved. Though this situation no longer legally obtains, it is the common experience of black litigants that judges and juries are often likely to outweigh the testimony of several black witnesses with the testimony of one white one and that in a personal

injury case the leg or arm of a white litigant is valued more highly than that of a black one.

In the past, in some statutes different penalties were set out for whites and blacks for the same offense. Though this is no longer the case, sentencing patterns often reveal a significant disparity between sentences meted out to blacks and whites for the same offense. One of the most egregious areas in this regard is in death sentences for interracial sex crimes. Sexual mutilation was at one time the statutory penalty reserved almost exclusively for blacks and Indians for interracial sex crimes. Since the 1930's, 455 persons have been executed for rape in this country; 405 were black. Where great amounts of discretion are involved—such as commutation of sentences—overall patterns of disparity of treatment can also be discerned.

The law, by reason of its structure —its procedural rules and substantive doctrines—operates to the disadvantage of the poor and minority person, bringing about a type of institutional subordination based on class and caste—class, because so much is related to the amount of money a person has; caste, because such a vastly disproportionate number of the poor in this country are also members of the nation's racial minorities.

A prime example can be seen in the operation of the money bail system, which jails one group of citizens for weeks, months, and sometimes years before trial, while another group goes free. Both are equally presumed innocent; money is the only discriminating factor and jails are packed with the nation's poor—the red, brown, black, and yellow men and women showing up in disproportionate numbers.

Problems are not, however, limited to matters of criminal justice. There is structural inequality in the owner-biased landlord-tenant law and creditor bias in commercial law. In administrative law as measured by the standard of due process required, there is often less respect and protection for the matters of concern to poor and minority citizens than that accorded major commercial and propertied interests. Today, large-acre zoning laws effectively put certain geographical areas off-limits to blacks. The law continues to deprive black people of effective political participation through the exercise of the franchise where "at-large" systems of voting can be used to assure that a black minority will never be in a position in a particular locale to elect a political representative of its own choosing.

Political repression—Political uses of the law certainly are not directed exclusively at black community activists, but the black community takes a large part of the brunt of the abuses of State power. Concern in the black community focuses upon the passage of new legislation that can be used as an instrument of repression: preventive detention, "no-knock," and "stop and frisk" legislation. The Interstate Riot Act which makes certain thoughts criminal if one happens to be thinking them while crossing a State line, is a ready weapon to attack politically active black spokesmen. Legislation that limits grand jury immunity and compels grand jury testimony upon pain of imprisonment supports governmental use of the grand jury process to suppress and inhibit political activism —a phenomenon of special moment to the black community at a time when it is attempting to coalesce and organize its efforts to secure change.

A more generalized trend in Supreme Court decisions toward the erosion of fundamental rights is another source of distress for black people.

There is concern about the paramilitary aspect of law enforcement with police resorting to some of the latest technological advances in equipment and weaponry to patrol and control black communities.

Police practices in dealing with black political spokesmen give black people further cause for pause and further support the view that the law continues to be an instrument of racism and repression. Informants too often are either unsound individuals or persons with serious charges or possible long sentencing facing them, who are told to produce evidence under circumstances that invite entrapment. There is the use of the *agent provocateur* who infiltrates political groups and instigates activity that may subject the members and leadership of the group to arrest and imprisonment —unsavory police practice detrimental to police image and the law in the mind of much of black America.

These practices must be seen against a backdrop of increased police surveillance of private citizens in many sectors of life—but especially political activity. The amassing of dossiers and keeping of data banks on persons quite unrelated to criminal activity has served both to anger and to chill those who seek to exercise First Amendment rights.

Electronic surveillance, or "bugging," invasions of privacy, and encroachments upon fundamental rights are a source of deep concern for people who for centuries had their lives constantly monitored and governed in minutest detail. In recent years the Federal Government maintained that it could conduct electronic surveillance in certain kinds of cases involving domestic security without first having to obtain judicial approval. The U.S. Supreme Court, however, recently held, unanimously, that the government had no authority to contravene our fundamental liberties.

The frequent charge of conspiracy in cases involving political activists is viewed as another example of political use of the law. Angela Davis, Bobby Seale, Erika Huggins, the Panther Twenty-one, the Chicago Seven, the Harrisburg Eight: All were faced with conspiracy charges—though none was convicted.

A further difficulty with the law that faces blacks in modern times is the harassment of those who would plead their cause—black and white lawyers who have taken on the defense of black activists have themselves become the objects of official sanctions —facing contempt, bar discipline, or even criminal charges. Part of the struggle of black people with American law today is to protect their protectors.

The inequities and failings of the legal system are capped by the barbarity and racism of a punishment system that is itself a crime. The warehousing of human beings in our nation's prisons is a national disgrace, which falls with disproportionate severity upon minority group prisoners—especially those who would organize in an effort to change their lot and end the crime of punishment.

Structure of the Profession

The law's racism—past and present —has been an obstacle to black advance in this country. Despite this fact, the legal system still carries with it the possibilities of positive change in many of the deprivations black people face in America. As long as the law is regarded as only a component in a much larger change process, and not a panacea, it is evident that it is much too valuable a tool for black people to abandon at this time—if ever.

What is ironic is that black people,

at one point in time, played a major role in shaping and carrying out the legal strategies addressed to the problems of their own liberation. Under the guidance and direction of such legal giants as Charles Houston, William Hastie, Thurgood Marshall, James Nabrit, Jr., and others, and with the intellectual support of the Howard Law School, great civil rights advances through the law were plotted and carried out. However, the situation of black leadership in the legal arena in the definition and solution of the major problems of black society in white America no longer obtains.

Racism is a problem that affects all who live in America; all have a stake in its eradication. Fair-minded persons should respect black people sufficiently to permit them to define their problems and lead in shaping the solutions. This is a crucial aspect of the black's empowerment, self-determination, and decolonization. It is, as well, rightfully a part of white people's liberation—liberation from paternalism, from patronizing, from dictating to blacks what black problems are and how they are to be solved. It is not an excuse for white abdication of responsibility or inaction in these areas. Close cooperation and close working relationships between the white and black bar are indicated. However, representatives of the white bar, foundations, and philanthropic sources need to be prepared to accept black leadership on matters of social policy where black people are primarily affected.

One of the most serious, if not the ultimate, of indignities is the tyranny of those who control the gathering and dissemination of the written and spoken word concerning the black situation. Black people cannot tell their own story without having it screened through white interpreters. In the 1970's, in the presence of so many fine, trained, and talented black legal personages equipped by training and sensitivity to address and interpret the black situation, it is a great affront to the black bar and the black community when those responsible for generating major commentaries on black people and their legal situation ignore and pass over all black scholars, writers, and practitioners in the decision of who will structure, guide, and control the content and nature of that publication. The audacity involved is overwhelming.

The black people, the black bar, and the black law schools must reassert their right of leadership and fashion an independent thrust based on a black perspective and on black priorities. All are welcomed to join the effort, for it is only in the pooling of all available resources that any real hope of eradicating racism lies.

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Asian-Americans: No Model Minority

Bok-Lim C. Kim

Most people believe that Asian-American communities are highly stable and in full command of their social and mental health concerns. The maintenance of this myth that Asian-Americans are a model minority tends to exclude them from nationwide concerns and education, health, housing, employment, and social welfare programs. However, behind the busy, prosperous shops and restaurants of the Chinatowns and Little Tokyos are thousands of unattached old people living in poverty and ill health, children of immigrants left at home without adequate adult supervision while parents work long hours to support them, uncounted numbers of deserted and abused Asian wives and children of American servicemen, and professionally trained Asian immigrants working in humiliation and frustration in unskilled jobs who appear only as patients in psychosomatic clinics or suicide victims in police records. The increasing incidence of drug abuse and delinquency among young people has shattered the myth that Asian youths are "obedient and problem-free."

This article provides some information to help all human service workers recognize and deal effectively with the complex issues confronting Asian-American communities and the lack of resources for their resolution.

Asian-American Communities

The predominant groups of Asians and Asian-Americans in the United States are the Chinese, Filipinos, Japanese, and Koreans. The Burmese, Indonesians, Guamanians, Samoans, South Vietnamese, and Thais are becoming significant groups as well. Merely listing these groups gives one an idea of the heterogeneity of history, religion, language, and culture of the Asian-American communities, plus the differential immigration patterns and the ways each group has accommodated itself to discrimination. For these reasons, each Asian-American community should be understood and dealt with as a distinct entity without masking the common experiences of racism and discrimination.

Asian-Americans tend to cluster in certain geographic areas (80 percent live in Hawaii and on the west coast) and form Chinatowns, Little Tokyos, and Little Manilas in large cities on the east and west coasts, mainly for self-protection and through lack of choice. Each Asian community has its unique sets of values, norms, organizations, and patterns of accommodating to the host community. The movement of the second and third generations from the ethnic enclaves to suburbia is directly related to the relaxation of discriminatory housing ordinances, the change in public attitudes toward minorities in general, and the improvement of socioeconomic conditions.

There is no consensus about who should be considered Asian. Lacking a meaningful classification system, Asian-Americans will be defined as those who reside in the United States, who share either Mongoloid or Malayan racial characteristics, and whose ancestors originated from the East Asian continent and its immediate surrounding areas.

Racism

The Kerner Commission report established that the United States is

racist. Although economic development and expansion of the frontier necessitated importation of cheap laborers from Asia and slaves from Africa, these peoples were never meant to be absorbed into the American mainstream. Nonwhites were easily discriminated against because their skin color allowed for quick differentiation, and thus prevented their assimilation. Five mechanisms have helped the white majority maintain racism: prejudice, discrimination, segregation, isolation, and exclusion and genocide.

The Chinese—Chinese immigration was stimulated by catastrophe and political unrest in China and the promise of opportunity in the United States. Many who fled intended to return eventually to China.

When the first group of Asians appeared on the American frontier in 1850, slavery for blacks and reservations for American Indians were well established. However, these Chinese immigrants were neither enslaved nor corralled. They arrived a few years after the rise of industrialization and urbanization when this country needed a mobile, docile labor force to work in railroad construction, mines, and new urban factories.

On the west coast—especially in California—hostile public opinions and violence against the Chinese occurred partially from ignorance, fear, and threat to jobs, but the overriding factor was clearly the white supremacist ideology. In 1854 the California Supreme Court ruled that the Chinese should be added to the list of races (including blacks, mulattos, and Indians) ineligible to testify against or for a white man. This ruling opened a floodgate of anti-Chinese abuse, violence, and exploitation and provoked the term "a Chinaman's chance."

From 1850 to 1870, California's Foreign Miner's Tax was collected from Chinese miners, who during the first 4 years of the tax had to pay 50 percent of the total revenue obtained from the mines and, during the next 16 years, 98 percent. In 1855 the California State Legislature imposed a head tax of $55.00 on the Chinese. The practice of unconstitutional restriction, taxation, and exclusionary measures against the Chinese in employment and property ownership became national in 1882 when Congress passed the Chinese Exclusion Act which prohibited immigration of Chinese and limited the formation of Chinese families and the development of a viable Chinese community. It also excluded Chinese immigrants from becoming naturalized citizens and introduced the category "Alien Ineligible for Citizenship," which raised barriers to civil rights and privileges.

The Japanese—Japanese immigrants arrived in Hawaii in 1885; others came later to the west coast. Immigration was stimulated by Japan's establishment of diplomatic relations with the United States after Commodore Perry's visit to Japan in 1854 and the active recruitment of laborers by the Hawaiian Sugar Planters Association in the same year.

Early Japanese immigants were young unmarried men who were eager to improve their economic condition. However, they became the target of the anti-Chinese elements on the west coast. To make the situation worse, the first tensions developed between Japan and the United States soon after their arrival. From 1900 to 1941, Japanese immigrants in California were, in effect, hostages or pawns in a great power competition for the dominance of the Pacific. Discriminatory laws and ordinances and violent mob actions were launched against the Japanese in California and other Western States.

On the Federal level, the Executive Order of 1907 prohibited further Japanese immigration from Mexico, Canada, and Hawaii, although wives of Japanese men residing in the United States were allowed to join their husbands, one reason why the Japanese community developed along different lines from the Chinese. "Yellow Peril" agitators, particularly labor leaders and politicians, caused enactment of the Immigration Act of 1924, which excluded immigration by all Asians and shattered the American tradition of free immigration.

In view of the persistent and violent anti-Japanese and anti-Asian agitation, the internment of Japanese aliens and Japanese-Americans on the west coast in "relocation camps" after Pearl Harbor becomes comprehensible, even though two-thirds of them had been born in the United States and the remaining third were aliens forbidden by law to become citizens. This action was the outcome of a concerted campaign to eliminate the economic competition of Japanese-American businessmen and to exploit the public fear generated by the sudden attack on Pearl Harbor. The danger of sabotage or espionage and protection of Japanese-Americans from mob action were flimsy excuses when one considers that no measures were taken against German-Americans and Italian-Americans.

Japanese-Americans asked that they be allowed to serve in the armed forces. The bravery and important contributions of the 442nd Regimental Combat Team in the European Theater and the military intelligence work of Kibei's forces in the Pacific Theater are now history.

The Filipinos—From 1907 to 1926 the Hawaiian Sugar Planters Association brought 100,000 Filipinos to Hawaii. The Spanish-American War of 1898 gave the United States trusteeship over the Philippines, so Filipinos were considered nationals although they were never granted the rights and privileges of citizenship.

The experiences of Filipinos have been similar to those of the Chinese and Japanese with one exception. Because of prolonged Spanish and American presence in the Philippines, Filipinos had taken on some Western values and culture, but their alleged "sexual aggressiveness" toward white females enraged Americans. The existing miscegenation law against Blacks, American Indians, and Orientals was quickly amended to include Filipinos. Filipino immigration came to an abrupt end in 1935 when deferred independence was granted to the Philipines. Immediately a quota of only 50 immigrants to the United States each year was imposed.

Between the Immigration Act of 1924 and the Immigration and Nationality Act of 1952, Congress passed a number of legislative measures that affected Asians. In 1943 Congress granted the privilege of naturalization to Asians and permitted immigration of spouses and children of Asian-American citizens. Finally in 1965, Congress abolished the restrictive National Origins Quota System.

Recent immigrants—Since World War II, the largest group of Asians to enter the United States as nonquota immigrants have been the wives of U.S. citizens whose entries have been facilitated by time-limited special congressional bills. U.S. Immigration Service officers indicate that the majority married soldiers overseas. Another significant group of nonquota immigrants includes orphaned or racially mixed children from Hong Kong, Korea, Japan, Taiwan, and South Vietnam adopted by white families in the U.S.

By far the greatest influx of new immigrants come from Hong Kong, Taiwan, Korea, and the Philippines. The number of new immigrants, long-time residents, and American-born Asians within each Asian group varies —which in turn produces different levels of community organization and social, economic, health, and welfare problems and needs.

Issues and Problems

Basic survival issues such as income maintenance, housing, education, health care, unemployment and underemployment, and vocational training and retraining are immediate problems for the aged, physically and mentally handicapped, and new immigrants among Asian-Americans. Because of language and cultural barriers and unfamiliarity with the institutional arrangement of a community, many needy Asians, particularly the aged and new immigrants, do not seek out services to which they are entitled.

Equally serious barriers to service delivery are the insensitivity, ignorance, and inadequacy of the community agencies that prefer to maintain the myth that Asian-Americans are successful and take care of themselves. The conflicts experienced by those caught between the value systems of their parents and American society and their frustration and anger at the society that has excluded them from the major decisionmaking institutions are serious problems for both the Asian communities and the larger society.

The problems of (1) those who immigrated prior to the Asian Exclusion Act of 1924, (2) the nonquota war brides and adopted children of U.S. citizens and quota immigrants who immigrated after World War II, and (3) American-born second-, third-, and fourth-generation Asian-Americans are sufficiently unique to warrant different approaches by the social work and human service professions. For example, unemployment has different causes in the three groups; therefore, it calls for different measures. For the first group it is likely to be related to poor health and marginal job skills. For the second group, it might be related to their inability to express and demonstrate training and skills and/or restrictive union or licensing practices. For the third group, it might be the outcome of alienation or poor educational preparation.

Responses

In response to these social problems, many self-help grass-roots organizations have emerged in the large Asian-American communities to provide much-needed services to delinquents, new immigrants, and senior citizens.

The Asian American Social Workers Association in Los Angeles was successful in forcing the California State Department of Public Assistance to add bilingual and bicultural Asian social workers to serve Asian communities in the Los Angeles area. More than a dozen projects and programs have been proposed on both coasts for provision of services uniquely suited to each Asian community. An 8-month demonstration and research project—"Demonstration Program for Asian Americans"—to determine the needs and problems of the Asian communities on the West Coast was funded in 1971 through Region IX of the Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare. The Mental Health Training Center for Asian Social Workers, started in 1972, trains social workers in new ways of working with Asian-American communities. In New York City, the Chinese Planning Council

combines direct services with planning and coordinating functions for Chinatown, a vital link between the social welfare community and Chinatown and among the Chinese organizations within Chinatown.

On a national level, the Council on Social Work Education established the Asian American Task Force within its Minority Commission. The Task Force members—Asian social workers, students, and faculty—have been working to set priorities and develop mechanisms to increase the number of Asian students and faculty in schools of social work and to establish relevant curricula and fieldwork placements.

The 1972 National Conference of Asian American Mental Health, sponsored by the Asian American Social Workers Association and the Minority Center, National Institute of Mental Health, provided a forum for Asian-American community workers and leaders to discuss the mental health of Asian-Americans. Eight workshops were concerned with the issues of Asian-American identity and personality; mental health needs of the aged, children, adolescents, families, and recent immigrants; the accessibility and effectiveness of the existing mental health programs; and the impact of mass media on both Asian-Americans and Americans. The conference recognized institutional racism and the need for affirmative action programs to overcome it. Self-determination and community control of programs affecting Asian-American communities were the basic premises, along with the need to define mental health and illness among Asian-Americans from their perspective so that the inadequate and false labeling of traditional psychiatric services may be replaced.

The needs for services of new immigrants and the lack of community resources and manpower to serve this population were expressed. The lack of reliable demographic data on Asian-Americans and the paucity of research on various aspects of coping, adaptation, accommodation, community development, and community organization patterns among the different groups and generations were also recognized. Concrete proposals to stimulate specific areas of research, such as identification of barriers to the use of community services and means of overcoming them, were made. Training of bilingual and bicultural workers in social welfare and health was considered one of the top priorities in view of the keen shortage of such personnel.

The involvement of the social work profession in direct services, training, and research is mandatory. Collaborative relationships between Asian-Americans and schools of social work, social agencies, and national organizations are essential for effective and responsible problem-solving in social welfare and race relations in this country today.

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Second-Order Effects in Mental Health Treatment

Anthony M. Graziano and Robert S. Fink

The contract of client and mental health professional entails the interaction of at least two complex systems, yielding both positive and negative first- and second-order effects. Our major focus is on the suggestion that there may be important negative second-order effects of mental health treatment. Our intent is to open the question for discussion, suggesting that while the therapist focuses on psychotherapeutic change in those areas traditionally defined as problems he may be unaware of other serious problems in the client's life occasioned by the therapeutic intervention itself. Focusing on outpatient settings, we propose a model for identifying and evaluating the effects of treatment, and suggest possible treatment-contingent, negative second-order effects that, we believe, are typically ignored by the profession.

Intervention effects—Many psychiatry and abnormal psychology textbooks suggest that therapy operates along a dimension of positive change. There is little discussion that there may also be other, possibly negative, effects. Therapy is presented as an ultimately low-risk procedure for the client—if it succeeds, the client will be "better," and if it fails, the client will at least be no worse, provided that he enters into therapy with a reputable, duly certified therapist. Possible negative consequences of treatment are admitted only when the "therapist" is "unqualified" or outside of the professions' certifying system. We suggest that effects of mental health intervention vary in both directions, positive and negative, and that the profession typically ignores the events on the negative end.

Processing the Client Through the Professional System

The mental health professions provide a system of personnel and agencies that offer evaluation and subsequent treatment carried out in a variety of settings and forms. The client interacts with the professional system on many levels, generating a variety of complex effects. The treatment process, then, is here conceptualized as constituting multileveled interactions of at least two very complex systems—the client and the profession—yielding equally varied and complex interaction effects, generating changes within both systems. The client system is the object of changes that may be conceptualized as primary or first-order effects (i.e., effects which are sought, created, and "tracked" by the therapist); secondary or second-order effects of therapy (i.e., those occurring outside of the planned control and scope of the therapy orientation, and are therefore not "tracked" by the therapist, or considered to be within his area of concern or responsibility).

The complex interaction of client and professional system may generate directions of change characterized as first- or second-order, and positive or negative, effects. Positive first-order effects constitute the essential perception of the goals of the field by professionals. Positive second-order effects, while not actively occasioned by the therapist, are happily accepted when they occur. Negative first-order effects lie in that area proscribed by current professional ethics—the ethical therapist does not actively and directly seek negative first-order effects on clients. This cell is generally assumed to be empty; that is, because we are ethical

professionals, negative first-order effects do not occur. Negative second-order effects are the present article's area of concern. While the clinician accepts positive second-order effects, he does not admit the possible existence of negative second-order effects.

The effects represented by each of the four conditions are simultaneous occurrences, generated contiguously by the interaction of the client and professional system.

Some Suggested Classes of Second-Order Effects

"Dropouts" from the mental health system—First-order effects presumably occur to their greatest degree with those clients who complete treatment. What proportion of all people who enter the system actually complete the treatment process and thus receive, supposedly, the maximum of positive first-order effects?

Relevant studies suggest that the proportion of dropouts may be extremely high, but research has been both inconclusive and contradictory on the reasons for client dropouts. Discussion of the major factors in dropouts has focused on patient characteristics; therapist characteristics; situational factors, including external variables in the patient's life; and patient-therapist interaction variables. The category of situational factors, which seems more amenable to objective study than the others, has been studied the least; most of the research seems to have been focused on patient characteristics.

There is agreement but little data to show that situational factors, including external and environmental factors, affect length of stay in treatment. These include difficulties arranging transportation, babysitters, time off from work, and a variety of other inconveniences that are ordinarily not seriously considered to be a part of the professional's concern. Lower-social-class clients both reject and drop out from treatment more frequently than higher-social-class clients. High fees and perceived social stigma, both of which may have more pronounced negative effects on lower social classes, are also factors in dropouts. Available evidence suggests that a large proportion of persons who enter the mental health treatment system do not complete the total process. It may be that salutary first-order effects actually occur with only a small proportion of all the clients who enter the system. There are selective processes, most of which are not now under the professional's control or perhaps even within his area of concern, that markedly reduce the number of clients who derive maximum help from the treatment process.

When a client drops out of the system, it is often seen as "resistance" or low motivation to be helped. However, we must consider the possibility that by providing services without recognizing that treatment demands may set up new and difficult conflicts with the client's environment, we may be responsible for actively attracting and placing individuals, and perhaps whole families, in untenable situations, creating or compounding problems for them.

Psychotherapy is only one of several possible avenues for solving personal problems (e.g., talking with a minister, getting married or divorced, finding a new friend, or "going it alone")—and it is not even certain that it is one of the more effective. Do clients explore all possible avenues of help before undergoing psychotherapy? If they do not, why has the professional mental health system attained its high priority as a helping resource?

A case in point is the common use

of waiting lists. It has been argued that long waiting lists serve the agency's needs and are contrived without regard for the possible negative effects on clients. The waiting period created and maintained by the professional system may be a strongly negative experience for the client—a negative second-order effect of the treatment process.

Dropouts from the treatment system constitute a large population which might provide information on some of the major weaknesses of the treatment system. This population has not been studied, perhaps because the "weaknesses" have been summarily attributed to client characteristics. Research is needed on the relationship between period of waiting and eventual degree of completion of the treatment process, on what ultimately happens to these dropouts as compared with clients who complete treatment and controls who never sought treatment, and on clearly identifying the major factors including client and treatment variables that account for the dropouts.

Labels and "sick" roles—The client has frequently received some mental illness label prior to entering the mental health system either through self-labeling, an informal judgment by friends or family, or a formal judgment of the court.

On entering the treatment system, the client is labeled. The labeling, applied by a socially legitimized professional, might in effect legitimize the previous judgment. This may provide the impetus, with or without the explicit sanction of the professional, for others to regard and treat the client as someone who cannot handle his problems or who may lose control of himself.

Labeling may reinforce the client's belief that he is disordered or incapacitated in ways that have no realistic basis. This label sanctions his adoption of a sick role. He may lead a less active, more limited life, and he may tend to orient his behavior according to his own impressions of how a mentally ill person acts and to the expectations conveyed by others. This process may lead to a "career of chronic deviance."

There can be other ramifications of being a mental health client: In order to avoid the social stigma, a client and his family may decide to keep his treatment a secret—leading to the precaution of being distant, vague, or misleading with employers, friends, or school authorities. Or, the client may choose to speak openly about his therapy, causing others to respond to the client as though he is incapacitated, "crazy," or delicate.

In terms of family dynamics, the client may be the object of attention and sarcasm as the person who is going to a mental health professional; other family members may worry about what he is telling the professional about them. Further, if his treatment places a financial burden on the family, then he may severely blame himself for the changed family life or financial and/or employment readjustments.

It may be argued that all medical treatment systems entail unavoidable, negative second-order effects. However, there is a "permanence" to the "mental illness" label and role that is not characteristic of typical somatic "sick roles." When, for example, a person returns from the hospital after an emergency appendectomy, the label "sick" is extirpated just as neatly as the offending organ. But not so for the sick neighbor who has just returned from a stay in the county mental hospital. The hypothesized negative second-order effects of the mental health treatment system may thus be

effectively permanent, while those of other treatment systems are temporary.

Demands imposed by the professional system: Fees and schedules—The professional system imposes new demands and constraints on the entering client—demands which, in addition to whatever problems led the client to seek treatment, require new strategies or coping behavior. These, in turn, might negatively complicate the client's already difficult life.

Fees constitute new demands on the family's financial resources—possibly resulting in significant changes in the family's life style. While the impact of mental health costs will vary among clients, we can speculate about changes in life style that may be contingent on fees for mental health treatment:

The client or family might have to reduce other expenditures, foregoing some amenities, education, important purchases, or vacations in order to meet treatment costs. The family may increase financial dependence on others (banks, friends, relatives). Changes in the working patterns of an individual or within a family may be required to meet fees.

In addition to the demands imposed by high fees, therapy also demands a clear time commitment by the client, often scheduled at the therapist's convenience. This, in turn, may result in the following:

In order to comply with the therapist's schedule, the client may have to interrupt his normal commitments, such as taking time away from or making special arrangements for work, school, family interactions, homemaking, etc. It may be necessary for the client to reduce his working hours in order to keep therapy appointments; in addition to loss of hourly wages, time loss can also create conflicts with fellow workers and employers. The client may feel considerable embarrassment in requesting his employer to allow him time off in order to receive treatment. More subtly, the employer, now cognizant of the employee's client status, might alter his perception of the client's value or future ability.

Overall, the potential effects of the client role and label on employment may be of serious consequence in the life of the client. However, there has been apparently little recognition or assumption of responsibility by therapists when such problems do arise.

Therapy outcome is the summation of mutually antagonistic positive and negative changes that are generated simultaneously by the treatment process. Outcome, therefore, depends not only on the power of the first-order change methods, that is, therapy techniques, but also on the value of the simultaneously generated negative effects. Our argument is that while first-order negative effects are presumably rare and of low weighting, being proscribed by professional ethics, second-order negative effects, typically not perceived by the therapist, are of unknown value. In cases where their value is high, they may significantly reduce the overall positive effects of the treatment. Utilizing a systems model in future investigations may help us to identify and control those treatment variables associated with negative effects. The resulting, more clearly isolated, positive treatment variables can then be directly tested.

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Accountability in Psychotherapy: A Test Case

Teodoro Ayllon and William Skuban

In recent years much concern has been focused on assisting the consumer by means of a critical examination of rising costs and the poor distribution of medical services. The time is drawing near when public scrutiny and concern for cost-effectiveness will demand accountability in the services provided by the mental health industry. Criticism has already been registered against the high cost of mental health care and its frequently equivocal results. From within its own ranks, the mental health industry has been accused of being foppish and of utilizing rhetoric to mask its inequities and ineffectiveness. For example, psychotherapy, the traditional treatment of choice, has been the target of criticism from its consumers as well as from professionals who have analyzed the effects of therapy. It seems likely that as consumers become more aware of the inadequacies in mental health services, they will demand consistent and clear results from psychotherapy.

Anticipating these problems, there have been suggestions to reform psychotherapy to meet many of these consumer objections. For example, it has been suggested that a business-type contract be drawn up between therapist and client before therapy begins. While the notion of a therapy contract may no longer be new, its adoption might well be hastened through empirical research.

The objective of this study was to answer some questions involving the feasibility of a contractual approach to psychotherapy: what implications contractural agreements present for the therapeutic process; what the merits are of different therapeutic strategies in the light of contractual agreements; what kinds of client guarantees are possible; how to assess outcome to provide evidence to both therapist and client of success or failure of therapy. These questions were examined for use in a contractual agreement to treat an emotionally disturbed child.

Case History

Subject—Mike, an 8-year-old white male, was the subject. The child had episodes of tantrums and negativistic behavior at home and in other settings. He had been diagnosed as brain-damaged, emotionally disturbed, mentally retarded, and autistic. Efforts to enter him into a special school had met with failure because of his hyperactivity and general lack of control.

The family—Mike had one sister (age—2.5 years) by his mother's second marriage. His mother nearly miscarried twice while pregnant with him, and delivery was premature. The stepfather was employed as a personnel trainer. He had attended college but did not graduate; the mother graduated from high school. The family resided in a middle income apartment complex.

History—Mike's mother considered him "different" from birth. After a brief period in kindergarten, he was expelled because of uncontrollable behavior. Psychological evaluation indicated that he had serious visual-perceptual and motor coordination problems. A neurological examination indicated brain damage; EEG patterns, however, showed little signs of irregularity. His mother merely thought that Mike was "bad." At this time she enrolled him in a special school where officials reported that he was "aphasic."

The mother reported a history of difficulty in controlling Mike, more so in public places. At home, while the episodes were less embarrassing, they were just as severe. Almost any demand on the child would occasion noncompliance and tantrums.

After failing in their handling of Mike, both parents attempted more direct and drastic methods. These included putting him in the bathroom, withholding privileges, hitting him, calling him names, and using a hand inductorium. None was successful. At the time of the behavioral assessment, his mother stated that life with Mike was "hell on earth."

Diagnostic test results—Before Mike could be admitted to a special school, he was required to have a psychological evaluation. The results of the psychologist's evaluation stated:

> Because of his uncontrollable behavior in a demanding test situation, all results indicate that Mike is functioning at a severely retarded level. There were several instances of echolalic speech patterns and almost constant screaming at a temper-tantrum level. The manipulativeness of these outbursts was evident from the first; there were no tears and there was no affect behind the screams.

Behavioral assessment—As school officials turned down Mike's application for admission when they received the report, his family decided to seek help in a program for autistic children which was under the direction of the senior author. A cotherapist became acquainted with Mike in an empty classroom. He discovered that if he did not do exactly as Mike said, the consequence was loud crying. If he asked Mike to do something, severe tantruming resulted. At this initial meeting, the only stereotypic autistic behaviors observed were when Mike, asked not to climb a sliding board, responded by screaming, biting his hand, and slapping his head.

A look at these episodes suggested that Mike had learned how to control adults. Since Mike's interaction with adults involved antisocial behavior and tantruming, we decided to record the frequency of his following instructions and the frequency and duration of temper tantrums associated with requests:

> 1. *Following instructions.* Following the instructions of adults was defined as starting the behavior within 10 seconds of the request and completing it. This condition had to be fully met before the response was scored as positive. An example might be: "Mike please sit down in this chair." If he walked to the chair, scoring was withheld until he finished the specified behavior. If he made no movements toward complying within 10 seconds, this was scored as noncompliance. After a minute, this was again scored as noncompliance. Then a procedure was used whereby the therapist physically guided the child to facilitate voluntary compliance.
>
> 2. *Tantruming.* A temper tantrum was defined as crying, loud whining, falling down, foot stomping, screaming, throwing objects, or hitting the therapist. If any of these behaviors took place within 15 seconds of a request, they were scored as a tantrum. If the tantrum ceased for more than 15 seconds, the episode was considered terminated. Another unit of observation then began whereby the therapist made a request of Mike, which could be the same as the previous one or a new one.

The therapy contract—After discussions with the parents the therapists drew up a therapy contract for the parents to read before treatment began. The contract specified the objectives of therapy, its duration, and what constituted criteria of success. The contract stated the objective—to equip Mike with significant social and academic behaviors to gain admission to school. Specifically, the treatment was to reduce the child's high rate of tantrum behavior from 46 percent to less than 5 percent of the time, and to increase his rate of following adult requests from 59 percent to above 80 percent of the time.

The contract specified that therapy would terminate after 35 days of a program of rehabilitation. At this time a test session would be held with the parents present, and if the objectives were met, the therapist would receive his full remuneration; if not, he would receive only two-thirds.

A Contingency Contract for Therapy

I. *Overview of problem and therapeutic program*

The overall objective of this therapeutic program is to develop and stabilize Mike's behavior patterns so that he may be considered for admission to school this fall. In general, this will involve strengthening some requisite behaviors such as following commands from an adult, and eliminating others, such as the screaming and tantruming that accompany most of his refusals to follow instructions.

Mike has a discouraging behavior history for most teachers to consider working with. Because his characteristic reaction to requests is to throw tantrums, he is considered "untestable" by standard psychological means. This does not necessarily mean that he cannot do the items on a test, but rather that he has little or no control over his own behavior. His uncooperativeness quickly discourages most people from making much of an effort to work with him. What is clearly needed is an intensive rehabilitation program designed to enable Mike to build patterns of self-control which would lead to the elimination or drastic reduction of his disruptive behavior. This, in turn, would open other possibilities for developing Mike's potential, that is, the avenues which are blocked by his unmanageable behavior.

The overall goal of this 8-week program will be the development of self-control with its reciprocal outcome of decreasing or eliminating tantrums and disruptive behaviors. Implementation of this program will require that the child and his trainer engage in such activities as trips to the zoo, museums, parks, movies, swimming pools, shopping centers, supermarkets, and so on, as well as having lunch and snacks together. These settings are included to expose Mike to a maximal number of normal situations where expectations of a standard of conduct are imposed by the setting itself.

As much as possible, the techniques used in the day program will be designed with the ultimate objective of utilization in the home. An attempt will be made to see that procedures used in the program are transferred to home management at the termination of treatment. The therapist will give instructions weekly to the parents by phone to insure that efforts both at home and in rehabilitation do not conflict.

II. *Behavioral objectives of therapy*

1. The objective of the therapeutic program is to teach Mike to comply with between 80-100 percent of the verbal commands given to him by an adult(s). Compliance will be defined as Mike's beginning to perform the behavior specified by the command within 15 seconds after it has been stated and then completing the specified task.

2. In addition, we intend to eliminate or drastically reduce Mike's excessive screaming and tantruming. The goal is not to tantrum more frequently than once out of 30 commands and for no longer than 1 minute at a time.

3. Evaluation of treatment outcome: The decision as to the attainment of these specific objectives will rest upon Mike's performance during a 30-minute test session to be conducted in a classroom situation. At this session the therapist, the parents, and an additional person will make 10 verbal requests each of Mike, for a total of 30 verbal requests. Mike must comply with 80-100 percent of these requests for the program to be considered a success. In addition, he must have tantrumed not more than once, and for not more than 1 minute, during this final evaluation.

III. *Time and place of therapeutic intervention*

1. The therapeutic program will start on _____ and terminate on _____ Evaluation of the effectiveness of treatment will be held on or about the termination date of the therapeutic program.

2. Location: The meeting place will be at the _____ Session activities, however, will involve time spent elsewhere, for example, having lunch, trips to shopping centers, amusements, and other special events. If the facility is not available, some other place agreeable can be designated as meeting and base center.

3. Days of training: Therapy sessions will be scheduled 5 days per week. The specific days may vary from week to week to comply with the objectives of the program. The family will be advised of the therapy schedule 1 week in advance.
4. Hours per day: Therapeutic sessions will be scheduled for 7 hours a day. Session time may be extended when therapeutically necessary as decided by the therapist.
5. Absences: There will be four notified absences allowed. The mother is expected to notify the therapist at least 1 hour before the scheduled therapy session. Any additional absences will require an additional fee of $10 per absence.

IV. *Fees*

Achievement of the behavioral objectives is expected to take 7 weeks of training from _____. This training will cost a total of _____.
The monies will be disbursed in the following manner.
1. A check for two-thirds of the total amount will be given to the therapist at the beginning of therapy.
2. The balance of one-third will be paid to the therapist upon the achievement of the program objectives as specified above on about the date of termination of the program. In the event that the above objectives are not reached by this date, therapy will be discontinued and the balance will be forfeited by the therapist.
3. All expense incurred during training will be defrayed by the therapist. This will include admission to baseball games, the city zoo, swimming pools, and so on, as well as the cost of field trips, lunch, and snacks.

* * * *

By my signature I do hereby attest that I have read the above proposal and agree to the conditions stated therein.

_____
Parent

_____
Supervising Therapist

_____ _____
Date Cotherapist

Behavioral strategy—Instead of treating Mike's behavior in a clinic, he was exposed to a number of public places, so that in each he could be taught social skills and self-control in relevant settings.

Behavior therapy took place 5 days a week from 5 to 7 hours per day. With the exception of personnel needed for reliability checks on the treatment procedures, the therapeutic intervention and observations were carried out by one person. The therapy sequence lasted approximately 210 hours. Observations and treatment procedures took place in banks, supermarkets, department stores, restaurants, public parks, a zoo, gas stations, shopping centers, and homes of acquaintances.

Therapeutic procedures were evaluated daily by sampling Mike's responses to sets of 10 adult requests on approximately an hourly basis. Recorded were: the number of requests complied with, the number of requests prompting a tantrum, and the minutes spent tantruming Measurement devices included a wrist counter, one hand counter, and two stopwatches.

The first objective was to develop social skills by increasing Mike's frequency of complying with adults' requests and decreasing his tantruming. These social skills were to be strengthened by increasing the behavioral requirements for reinforcement. Finally, we aimed at a transition to natural consequences for Mike's behavior by fading out contrived procedures used in therapy. In general, positive reinforcement—money—was presented contingent upon compliance with a request, while tantruming re-

sulted in time out from positive reinforcement.

A stopwatch was used to time Mike's compliance response. If he met the 10-second limit for the response, he received coins (pennies and nickels) which were controlled by the therapist who searched the child each morning for change. The coins served two functions as conditioned reinforcers. The child could use them to operate pinball machines, as well as coke and candy machines. Secondly, he could present the coins to the therapist to purchase items for him or grant him privileges, e.g., lunch, access to playground equipment for a set time, playing with toys, swimming privileges, pushing buttons on an elevator, playing catch with, and being tickled by the therapist.

Mike's earnings for a day normally ranged between 30¢ and 60¢. Throughout the training day, pennies were exchanged for various backup reinforcers, whose values fluctuated. A tickle by the therapist might cost one penny, while purchasing a coke out of a machine would be the machine cost of 10 or 15 pennies. Cost of providing Mike's backup reinforcers was $2 per day or around $75 for the treatment program.

Strengthening social skills—To insure that the gains made in the first therapeutic sequence would remain truming was relatively frequent. The first objective was to develop social control by reducing tantruming and increasing compliance. Specifically, the procedure for increasing compliance involved reinforcement (coins) paired with praise contingent upon compliance with a request. In addition, a discriminative stimulus—the movement of a stopwatch hanging around the therapist's neck—served to cue Mike when reinforcement was available. The stopwatch was left running except when it was turned off for tantruming. This procedure functioned as time out from reinforcement. When a tantrum occurred, Mike was reprimanded with a "no" and told the stopwatch was off. It was left off for the duration of the tantrum and for 1 minute after. When the hold time was over, he was told the watch was on and he could earn coins by doing what the therapist told him to do.

During the tantrum the trainer would turn away from Mike, withholding all social interaction. In some instances it was necessary to restrain Mike in order that a store not be reduced to rubble. In these cases a firm gripping of the arm was maintained while social interaction was eliminated.

Once social behavior was established, academic tasks became the requirement for earning pennies. These consisted of getting Mike to write his name, count to five, make left-right discriminations, and word identifications. After a short while the opportunity to do academic work ("schooltime") became a discriminative cue for reinforcement and was sought after by the child.

Strengthening social skills—To insure that the gains made in the first therapeutic sequence would remain stable, increased requirements were made on Mike for "stress points."

With the next 80 hours of therapy, Mike was given only praise for each request followed outside of "schooltime." When he earned five of these verbal reinforcers, he received a nickel which he could exchange for a "schooltime" session. Mike was also given a counter to be worn around his neck, and was told how to count his own "good boys." During this phase *only* the pennies (earned through academic tasks) were exchangeable for the backup reinforc-

ers; the nickels served only to gain access to the "schooltime" schedule.

Transition to "natural consequences"—The objective of the final therapeutic sequence was to approximate the natural contingencies utilized by parents in the social control of their children. Instead of coins Mike received only social reinforcement (praise) for being "good" (e.g., following instructions). After receiving much praise through the day, Mike was given a special treat on an intermittent basis. Since the therapist paid for these treats, Mike was in a sense on a daily allowance for following instructions. Mike's "bad" behavior, tantruming, was ignored. Mike's counter was taken away from him and other scoring and controlling devices were kept from sight, with the exception of the intermittent times when data was collected. The only visible piece of equipment remaining at this time was the therapist's wrist counter, which registered the frequency of praise given to Mike for following requests. A variable exchange rate was established between the total amount of praise given and that required for treats. Because of the variability of this exchange rate, Mike was often asked to look at the counter to see if he had accumulated "enough" praise to receive his treat.

The results show that when Mike was reinforced for following instructions and was placed on timeout for tantruming, his social skills increased.

During the behavioral assessment, Mike's following instructions given by adults averaged 59 percent. The use of money as a reinforcer in the first phase of behavior therapy increased this percentage by 24 points. By increasing the requirements for reinforcement in the second phase, Mike's rate of following instructions was further increased to 97 percent. When treatment devices were removed, Mike's high rate of following requests was maintained.

Much the same results were obtained with respect to Mike's major social deficit: tantruming. Mike tantrumed to 42 percent of the requests given to him. The first therapeutic intervention reduced this to 10 percent. The second procedure brought further improvement as tantruming was reduced to 2 percent of the amount seen during the baseline. The third therapeutic sequence maintained this improvement.

The dramatic changes in Mike's behavior were not limited to the frequency of his tantruming. During behavioral assessment the tantrums sometimes lasted as long as 33 minutes. The first treatment period decreased the duration of tantruming to 7 minutes. This improvement was increased during the second treatment sequence as the duration of tantruming dropped to 2 minutes. These improvements were maintained when natural control was approximated in the last sequence.

Evaluation of therapeutic procedures across therapists—To test for generalization of the therapeutic procedures, an evaluation was performed using another person in the role of therapist. The test was conducted over 3 days near the end of the first phase. A female graduate student, who had never met the child before, was briefed on the recording and treatment procedures. Mike and the new therapist went to a new setting. There Mike was given a series of instructions: first, under baseline conditions of no treatment, then under the treatment procedure, and finally, under no treatment conditions.

When the treatment procedures were not in effect, Mike's rate of fol-

lowing instructions fell and became erratic. In some cases he followed all the requests given to him during this baseline condition, in others only 20 percent. When the treatment procedure was instituted by the new therapist, Mike's rate of following requests increased to a perfect level—100 percent. As the therapeutic procedure was withdrawn, the rate of following requests deteriorated even more quickly, and again became variable. During the baseline period of no behavioral therapy, Mike was occasionally "perfect," but often tantrumed to 50 percent of the requests, and on one occasion to all of the requests. When the new therapist applied the treatment again, this aspect of his social behavior was brought under control. As the treatment was withdrawn, however, he quickly began to tantrum more frequently. The duration of Mike's tantruming was zero when the new therapist used the therapeutic procedures. When she did not, the duration of his tantruming increased.

Therapy Contract: Outcome Evaluation

As the contract specified, there was an evaluation of the outcome of the therapeutic program. Mike was given 30 requests by adults; 10 by the therapist, 10 by an adult Mike had never seen before, and 10 by his father. The only instructions given to the two participants were to smile and act "naturally" whenever Mike did something for them.

The results provide evidence of the success of the strategy and the efficacy of treatment. The therapy contract specified that Mike be able to follow over 80 percent of the requests given to him by adults. Out of the 30 requests given him in this test session, he successfully followed 93 percent. The contract stipulated that Mike would not tantrum more than once during the test period and that the duration be less than 1 minute. In the outcome evaluation Mike did tantrum once but for only 5 seconds.

The parents were asked to reexamine the therapy contract to insure that it had been satisfied and if so, to initial it. The father indicated that he was pleased and impressed with the straightforward nature of the contract which prevented him from getting the "runaround." With the contract fulfilled, the therapist received his full remuneration, and Mike was admitted into a special classroom of a regular elementary school.

The results demonstrate that clear, objective understanding of the expectations associated with therapeutic success is possible between the patient and the therapist. Contracts are feasible if aims are defined objectively. Aims in terms of hypothetical or internal events may remain beyond the purview of therapy contracts. It is obvious that the client prefers gains in the "real" world to those limited to a clinical setting.

Irrespective of the psychotherapist's approach, a therapeutic contract makes him accountable for the effectiveness of his techniques. More important, a therapeutic contract gives the patient or client the confidence that derives from knowing that his expectations will be realized at last.

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Mental Health News Digests

Mental Health of the Deaf

A new international organization, Group for Mental Health of the Deaf, has been created as an arm of the World Federation of the Deaf. Psychologists, psychiatrists, and others involved in mental health problems of the deaf are invited to contact Dr. Von der L. Leith, 40 Nelbegaardsbakken, Copenhagen, Denmark, for additional information.

Treatment Required for Addicts on Welfare

In order to receive public assistance in the State of Pennsylvania, applicants with a drug or alcohol dependency problem must accept available treatment and rehabilitation services for their illness or be declared ineligible for public funds.

County Assistance Office staff members will be responsible for identifying applicants with chronic alcoholism or drug dependency problems. They will then refer them to the proper county mental health program administrator for thorough evaluation of how the problem influences their need for public assistance. Placement in an appropriate rehabilitation or treatment program will be made mandatory before the Office will approve assistance funds.

Unified Services Bill

New York State has enacted a Unified Services Bill which coordinates State and county mental hygiene projects into one effective program where the individual can go for treatment. The law permits State and counties to merge their separate resources to provide mental health, mental retardation, alcoholism, and drug services to people of a participating community. Consumers and other providers of services are required to participate in community-based facilities and in State institutions.

The new law, workable July 1, 1974 for New York City and July 1, 1975 for other counties, contains provision for a services evaluation system giving local government legislative mandate to evaluate State programs from which county residents will receive treatment. Conversely, State program directors have a similar responsibility in local programs.

In addition, the State is required to conduct cost effectiveness studies of various unified services programs. Net costs of providing State services to county residents will combine with net costs of county mental health programs to form aggregate operating costs. The State will pay $10 per capita for the first 100,000 population, $5 per capita for over 100,000 population, 80 percent of the costs in excess of the two preceding items up to $13 per capita aggregate costs, and 65 percent in excess of $13 per capita; the county would pay the remainder. The State would continue to pay 100 percent of the capital costs of State facilities but would change its share of the local facility capital costs from one-third to one-half of the non-Federal share. Because of the increased State costs, there will be a 5-year phase-in period.

Unified services include: inpatient and outpatient services; partial hospitalization services such as daycare, nightcare, or weekend care; emergency services; consultation and education services to community agencies and professional and

associated personnel, and information services to the general public; preventive services; diagnostic and referral services; rehabilitative services, including vocational, educational, and training programs; precare and aftercare services, including foster home placement, home visiting, and halfway houses; staff training; research and evaluation; activities involved in bringing the needs of the mentally disabled to the attention of governmental and private providers of services; and other services which the commissioner approves.

Provisions are set forth for evaluation of different types and patterns of service; for construction, renovation, and improvement of State and local facilities; and for assurance of properly recruited, developed, and compensated personnel for these unified services.

The Commissioner has been assigned the power to operate community residential facilities as hostels for the mentally disabled in amounts not to exceed 50 percent of the total costs of such hostels; local government approval will be a requisite of the hostel service. (From *Mental Hygiene News,* 44(12), 1973.)

Training Program for Mexican Americans

Higher grades, fewer school absences, better health, less misbehavior, and a morale boost have resulted from the first year of a project to motivate a group of junior high school students in a Mexican American barrio in East Los Angeles.

One hundred students participated in the program with a control group of 500 being used. The students received medical examinations, individual and group counseling, and 10-week health and homemaking courses which included classes in nutrition, consumer education, child development, home nursing, sewing, use of mood modifiers such as drugs and alcohol, environment and disease, and sex education and family life.

Home visits with the family and weekly counseling sessions were conducted by advisors. All the families were registered with the East Los Angeles Child and Youth Clinic.

According to Dr. Paul F. Wehrle of the University of Southern California Medical Center, director of the program, the success of the project hinges on effectively combining mental health and physical health services through collaborative efforts of a medical facility and a public school; on using a social work counselor with a similar ethnic background; on emphasizing family rather than academic counseling; and on offering courses that are relevant to the students' lives.

During the second year of the project, 300 students will take part in the program. Funded for 2 years by the National Institute of Mental Health, this demonstration project should be of particular interest to city health and school officials and citizen councils who can tailor the program to their own communities and schools.

NIMH International Research Activities

Geographical boundaries and divergent ideologies are being bridged by NIMH in the field of mental health research:

The largest single international project supported by NIMH is a collaborative effort with the World Health Organization and involves nine nations in coordinated research into the epidemiology and psychopathology of schizophrenia. Field research centers have been established in each of the participating

countries—Colombia, Czechoslovakia, Denmark, England, India, Nigeria, the Soviet Union, and Taiwan. Objectives of the program are to develop standard diagnostic language and instruments, to train observers to acquire patient information applicable to the standard instruments, to translate the instruments into different languages, and to characterize patients from different countries in terms of social and cultural variables.

As part of the scientific exchange agreement between the U.S. Department of Health, Education, and Welfare and the Soviet Union, an NIMH delegation visited the USSR in the fall of 1972 to negotiate collaboration on another major research program on schizophrenia.

For several years NIMH has supported a multiethnic study in Hawaii. Aimed toward ascertaining the effects of cultural differences on mental illness, this study of psychopathology and normality involves native Hawaiians and Hawaiians of Japanese, Caucasian, Phillipine, Portuguese, Malayan, and Polynesian extraction.

Among the 20 mental health research projects that NIMH supports in 11 countries outside the United States are included: a London study of the impact of young children's psychological problems on later personality development, a Tel Aviv University investigation of the long-term effects of stress on psychological development, and brain research in Canada, Denmark, England, Italy, Poland, and Sweden.

In the area of drug abuse NIMH has implemented international efforts for research, planning, treatment, rehabilitation, education, and training through a number of multilateral agreements and through bilateral agreements with Canada, Mexico, Argentina, and Australia.

In Costa Rica, with the assistance of NIMH, a Center for the Study of Alcohol and Alcoholism has been created, and NIMH has established an International Reference Center for Information on Psychotropic Drugs, coordinating 20 Regional and National Reference Centers to exchange information on various drugs.

In order to help relieve the effects of stress resulting from last year's earthquake in Managua, NIMH is coordinating the voluntary work of teams of U.S. mental health professionals in that country.

NIMH anticipates increasing international scientific activities and interchange in the mental health field. (Adapted from Hathorne, B.C. World perspective on mental health. *Journal of Pastoral Care,* 27(2):73-74, 1973.)

Topeka Agencies Study Mental Health Services

A $150,800 research grant has been awarded to The Coordinating Committee of the Black Community, Inc. (CCBC) of Topeka, Kansas, by the Center for Minority Group Mental Health Programs of the National Institute of Mental Health to determine the needs, priorities, and solutions to mental health delivery problems in the black community.

The 3-year project is aimed at having the black community take prime responsibility for defining its own problems, assessing its own needs, and establishing its own priorities. The first step will be to acquire factual information on the demographic characteristics and needs of the population.

The CCBC is a consortium of nonprofit organizations; Ms. Eva L. Martin, Director of the CCBC, is the principal investigator.

recent nimh publications

Single copies of these publications may be obtained from the Public Inquiries Section, National Institute of Mental Health, Room 15C17, 5600 Fishers Lane, Rockville, Md. 20852. A complete list of all publications available from the NIMH may also be obtained from the Public Inquiries Section. If a price is given, the publication may be ordered in quantity from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Enclose a check or money order payable to the Superintendent of Documents.

Growing Up in America: A Background to Contemporary Drug Abuse. Authored by Anne McLeod, this book deals with studies of youth in inner city and suburban environments, with particular emphasis on the contemporary drug scene. Aims toward an understanding of the problems and views of young people who are confronted by the drug scene and discusses how, and at what point, we can best offer assistance. Annotated bibliography for teachers and a separate annotated bibliography for students. DHEW Publication No. (HSM) 73–9048.

Utilization of Mental Health Resources by Persons Diagnosed with Schizophrenia. Mental Health Statistics Series B, No. 3. Report examining schizophrenic patient care during 1969 through age, sex, modality of treatment, type of facility in which care was received, and patient care episodes. Recent utilization of psychiatric facilities by schizophrenics is studied to obtain implications for future patterns of use for these facilities. Detailed charts and tables. DHEW Publication No. (HSM 73–9110).

The Bethesda Longitudinal Study of Early Child and Family Development 1973. This 19-page booklet describes research studies of the young child's development and interaction with parents, beginning with the newlywed period of the parents, including the newborn period and early infancy of the child, and culminating in the school age of the child. The goal of the studies is to determine the effects of intimate relationships on a young child's development. DHEW Publication No. (HSM) 73–9088.

Drug Abuse in Industry. NCDAI Series 6, No. 1. An almost nonexistent problem 10 years ago, drug and alcohol abuse in industry and government has increased rapidly. This bibliography presents abstracts of problems such as industry's role in employing ex-addicts, security, safety, legal issues, drug policy development, recognition of drug abuse, and organizational prevention. NCDAI–26.

Crime and Delinquency Abstracts, Volume 8, Cumulative Indexes, 1972. This publication of the National Clearinghouse for Mental Health Information, which contained abstracts of current published literature and ongoing research projects in the field of crime and delinquency, will be discontinued with this issue. DHEW Publication No. (HSM) 73–9004.

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